

Monitoring AIDS Treatment Rollout in South Africa: Lessons from the Joint Civil Society Monitoring Forum (JCSMF)

Budget Brief No. 161

Nhlanhla Ndlovu and Rabelani Daswa¹

13 April 2006

For more information contact: Nhlanhla Ndlovu, AIDS Budget Unit at (021) 467 5600 or email: nhlanhla@idasact.org.za

Idasa is a co-founding member of the Joint Civil Society Monitoring Forum (JCSMF) and is releasing this brief as a summarized version of the JCSMF resolutions and minutes from meetings held over the past one and a half years, on behalf of the forum. The JCSMF was founded on 12 June 2004 by the Aids Law Project (ALP), Health Systems Trust (HST), Centre for Health Policy (CHP), AIDS Budget Unit at the Institute for Democracy in South Africa (Idasa), Open Democracy Advice Centre (ODAC), Treatment Action Campaign (TAC), UCT School of Public Health & Family Medicine, Public Service Accountability Monitor (PSAM) and Médecins Sans Frontières (MSF). The forum was formed to monitor and support the implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.

I. Executive Summary

There is a growing demand for AIDS antiretroviral (ARV) treatment amongst people living with HIV and AIDS in South Africa. Guidelines and procedural arrangements have been developed at national and provincial levels to accelerate the rollout of ARV treatment in the public sector. A few provinces started slowly and cautiously to provide the ARV treatment while most provinces' ability to provide the treatment was frustrated by a shortage of staff and general administrative and other competing demands. Capacity and political will remain central to the ability of the public sector to deliver required services.

At its inaugural launch, the Joint Civil Society Monitoring Forum (JCSMF) noted that political and managerial oversight as well as overall commitment to the ARV treatment

¹ The authors would like to acknowledge invaluable inputs from the Joint Civil Society Monitoring Forum (JCSMF) members, especially Ms Fatima Hassan of the AIDS Law Project.

plan vary from province to province.² It also reported that there is a lack of systematic national management and oversight. The most serious problems identified are:

- Severe human resource (HR) shortages in clinics and hospitals across the country.
- Wealthier provinces such as Gauteng and the Western Cape are scaling up much more speedily when compared to poorer provinces such as the Eastern Cape. National government and all other stakeholders should develop a plan to support poorer provinces. In particular, Limpopo requires urgent support as it has been reported as the slowest in rolling out the ARV treatment plan with progress moving at a 'snails pace'.
- Gaps in communication and information sharing: these appear to be mainly between the national and provincial health departments as well as between the national department, provincial health departments and civil society organisations. Examples of these gaps are with regard to data collection and management, patient outcomes, patient numbers, gender and age breakdown of people on treatment, treatment literacy and community awareness initiatives.
- Good outcomes of ARV treatment for children are dependent on timely initiation of treatment and implementation of proper and holistic subsidiary care programmes for children living with HIV.
- On budgetary aspects of the Operational Plan, there is a lack of clarity on the extent to which provinces are using conditional grants allocated by the National Treasury or using funds from their own budgets to implement the ARV treatment plan.
- Due to lack of disaggregation in HIV and AIDS expenditure reporting, it is difficult to monitor how the ARV budgets are spent on ARVs and other treatment-related spending areas (for example, laboratory services). This is important to monitor because there still remains a need to prioritise other areas of HIV and AIDS spending such as prevention and care and support.

II. Introduction

The Joint Civil Society Monitoring Forum (JCSMF) exists to assist Government with the effective and efficient implementation of the Operational Plan to ensure comprehensive HIV and AIDS care, management and treatment in South Africa, from a health and human rights perspective. It aims to help redress the inequities 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 JCSMF undertakes to assist with the monitoring and assessment of the implementation of the Operational Plan so that optimal patient targets can be reached within reasonable time periods. The JCSMF has an open membership base including civil society organisations, research institutes, health workers, private sector and government officials who have a direct interest in the implementation of the Operational Plan. The forum has had provincial officials participating but there has been no national participation to date.

² JCSMF. 2004. Inaugural Launch (1st Resolutions) of the Joint Civil Society Monitoring Forum for the Comprehensive HIV and AIDS Care, Management and Treatment Plan for South Africa. September 2004. Polokwane – Limpopo.

The JCSMF members have raised, through participatory discussions and workshops, some very important concerns which are central to the achievement of the Operational Plan's goals and objectives. Thus, this paper seeks to summarise key concerns and resolutions to inform the implementation process of the ARV treatment programme in 2006. It describes basic monitoring efforts developed for the implementation of the Operational Plan; identifies challenges to monitoring efforts; outlines key foci of the Plan which have somehow been neglected, such as reporting on paediatric access to ARVs, dissemination of ARV programme spending trends, capacity issues centred on human resource planning and management; and recognition of a major role that is played by the private sector and international aid agencies (donors) in the fight against HIV and AIDS.

III. What does it mean to monitor the 'rollout'?

The Department of Health (2004a) produced guidelines and indicators to monitor progress made in relation to the ARV rollout plan. Monitoring is generally defined as keeping track of events or activities to ensure effective and efficient service delivery. The Department of Health (2004b) defines monitoring as "the routine ongoing assessment of activities applied to assess resources invested (inputs) in the programme, services delivered (outputs) by the programme, and outcomes that are related to the programme." Monitoring involves various components, including information accessibility, budget issues, assessing target groups and capacity issues. The civil society's main interest is to monitor the process and pace of delivering ARV treatment to people who need it.

The aim of monitoring is not only to highlight shortfalls of implementation, but also to identify and develop ways of improving service delivery. Watchdogs also need to monitor the utilisation of public finances as well as outputs and outcomes of programmes being implemented. In this case, monitoring is aimed at access to adequate and sustainable ARV treatment by AIDS patients and effectiveness and efficiency of resource utilisation in the ARV programme. However, for watchdogs to monitor the effectiveness and efficiency of public services, they need to be well informed. Further, they also require sufficient capacity building, training and access to information and financial resources to play their role effectively. *The founding members of the JCSMF are to some extent advantaged to be able to support each other with necessary expertise to be able to actively play their monitoring role.*

1. Information monitoring

Access to or availability of information is a key determinant of a democratic state because openness determines to what extent citizens participate in public processes and service delivery. Without access to information we can hardly say that there is democracy. Democracy may be portrayed by the public's ability to contribute to and influence the state's decisions and programmes. ***With regard to ARV rollout, it has been reported that access to information has been a major challenge.***³ Reportedly not all provinces have been willing to provide information in this regard. This has made

³ All the JCSMF meetings (starting from the 1st meeting held in Limpopo Province on 7 September 2004 until the latest 7th meeting held at Orkney, North West Province on 6 March 2006) have identified information inaccessibility as being a major challenge to monitoring of the Operational Plan.

monitoring and development of appropriate resolutions difficult. It has also encouraged civil society to question the democratic state of the government. In addition, the Treatment Action Campaign and the AIDS Law Project (2004) reported that “information sharing is important because people who are to benefit the most from the implementation are the poor people who need treatment in the public sector.”⁴

2. Timely response to request for information

The JCSMF has called on all provincial health departments and their respective units to timely respond to requests for information as prescribed by national legislation. It also recommended that the Chief Directorate for HIV and AIDS, STIs and TB disseminate collated ARV rollout information regularly to keep other stakeholders informed.

3. Budget information

Budgets are a good indicator of government’s commitment to the provision of public demands. Without budgets, priority public programmes cannot be implemented. Allocated budgets tell us about implementation priorities which may not necessarily be the most important policy priorities. Ironically, policy priorities on government policy documents are not real priorities if they are not accompanied by sufficient budgets for them to be implemented. This point is also important in the provision of ARV treatment because the national Cabinet emphasised the importance of and the demand for ARV drugs, and called for the health sector to develop appropriate plans for ARV treatment provision. It would be equivocal if this commitment is not matched with the necessary resources.

Notably, the health department agrees that a budget is one of the important inputs that need to be monitored. It proposed that funding will be monitored by sources, that is, in terms of provincial allocations, conditional grants from national government and donor aid. It also proposed monthly expenditure reports on standard items such as personnel, drugs and laboratory services.⁵ Although the South African government has very good budget documents which reflect how much is allocated to HIV and AIDS in general, these publicly available documents do not provide the disaggregated information required to monitor spending specific to ARV treatment.

How could civil society, researchers and Parliament know how much is allocated for AIDS treatment if the information is not made publicly available? One could argue that information is available from the provincial departments which are actually delivering treatment. Regrettably some of these provincial departments do not provide this information for public consumption. That is, the fact that provinces have budget information available does not mean that the information is available to everyone. Relevant actions need to be taken by civil society, Parliament and national government

⁴ Hassan, F. 2004. Updated First Report on the Implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. AIDS Law Project: Cape Town.

⁵ Department of Health. 2004. Monitoring and Evaluation Framework for the Comprehensive HIV and AIDS Care, Management and Treatment Programme for South Africa. September. Available from www.doh.gov.za (last accessed on 25 January 2006).

to ensure that provinces publicise budget and actual expenditure information as widely and publicly as possible.

Notably, the JCSMF called on government to ensure that the Operational Plan conditional grant spending reports are disaggregated at provincial level so that it is clear how these amounts are being spent.

4. Increased resource allocation

The JCSMF has agreed on a number of occasions that additional allocations for HIV and AIDS are required from year to year. However, provinces need to report how they spend their ARV allocations to be able to identify unmet needs or surpluses to be used for other HIV and AIDS interventions. The capacity for spending at provincial level must also be addressed. In particular, national government must find a way to assess the extent to which provinces are underreporting total health HIV and AIDS spending as opposed to actual spending and reporting only on conditional grants. This is necessary because some provinces such as KwaZulu-Natal and Gauteng are spending large amounts from their own budgets in addition to national government's conditional grants.

5. Children-related ARV treatment issues

AVERT (2006) reported that "of the 3.1 million [people] killed [by AIDS] in 2005, over half a million were children aged below 15 years. At the end of 2005, an estimated 2.3 million children globally were living with HIV. Lack of HIV and AIDS monitoring facilities in many less-developed countries means that it is difficult to produce precise estimates, and the actual figures could be higher."⁶ More than 230 000 of the HIV-positive children live in South Africa.⁷ "The high HIV prevalence among South African children is a major cause of concern. When the 2002 results were released there was a tendency not to acknowledge that so many South African children were infected with HIV. The estimated 129,621 children aged 2-4 years and 214,102 children aged 5-9 currently living with HIV/AIDS are significant numbers."⁸ It is also estimated that "at least 50 000 [South African] children need ARVs now, but that currently only about 10 000 are receiving them."⁹ Against this background, the JCSMF reported that several factors have prevented greater paediatric access to AIDS treatment, including:

- (a) The long time it took for the national Department of Health to finalise treatment guidelines for use by provinces resulted in some provinces reportedly developing their own guidelines before the finalisation of the national guidelines.

⁶ AVERT. 2006. Children, HIV and AIDS. 29 March. Available from <http://www.avert.org/children.htm>. (last accessed on 11 April 2006).

⁷ HIVInsite. 2006. HIV/AIDS-Specific Country Profiles: South Africa. March. UCSF. Available from <http://hivinsite.ucsf.edu/global?page=cr09-sf-00>. (last accessed on 10 April 2006).

⁸ African Studies Centre. 2006. South Africa: New AIDS Statistics. AfricaFocus Bulletin. 16 February. University of Pennsylvania. Available from <http://www.africa.upenn.edu/afrifocus/afrifocus021606.html>. 2006. (last accessed on 10 April 2006).

⁹ LearnScapes. 2006. "SA health department falling short of its goal". [Electronic] HIV/AIDS News (Newsletter) 136. Also available from www.learnscapes.co.za.

- (b) “Paediatric formulations are often non-existent or inappropriate for a low-literate society, difficult to estimate quantities, comparatively complicated and more expensive.”¹⁰
- (c) The “fear” of treating children (by doctors and nurses): given that adult treatment is the main focus, the inadequate and insufficient training on paediatric treatment contributes to health care workers’ (HCW’s) reluctance and fear.
- (d) The misconception that only a paediatrician can treat children with ARV medicines.

Further, the 5th JCSMF Meeting (29 August 2005) identified the lack of adequate provision of paediatric care in clinics, which it attributed to the obstacles inherent in the sharing of responsibility for primary health care services by local and provincial governments. Clinicians who serve as members of the JCSMF expressed extreme frustration by the impact this was having on the rational provision of care, such as the inability to transfer more paediatric ARV care to primary health care sites.¹¹

In addition, improved political commitment is required to increase health services for children and adults. This is linked to improved monitoring and evaluation which are urgently required to meet paediatric targets. PCR (Polymerase Chain Reaction) tests to detect HIV in infants and young children must be available at all treatment and referral sites. Such testing should be included as part of Integrated Management of Childhood Illnesses (IMCI) and linked to immunisation coverage. This will help track children who may need ARV treatment. “Improved technologies (PCR diagnostics) to diagnose children at the age of six weeks are currently available and part of national policy. These are utilized in the Western Cape, but apparently not beyond.”¹²

Education and advocacy concerning the treatment of children with HIV and AIDS within the medical profession must be improved so that children can benefit from the implementation of the Operational Plan on a much wider scale. Thus, “paediatric guidelines, along with more appropriate training, need to be used to encourage a more concerted effort towards achieving paediatric ART provision.”¹³ Initially, conflicting discussions on treatment guidelines indicated that paediatric treatment guidelines did not exist until very late in the implementation process. A Health Systems Trust Conference Report (2005) reported that “although paediatric guidelines had been developed by mid-2004, numerous (Free State) provincial representatives, including top paediatricians, were unaware of these. Accordingly, the Free State developed their own guidelines.”¹⁴ Again, this underscores poor information dissemination and insufficient coordination and communication between national and provincial health departments.

¹⁰ Doherty, J, Loveday, M, Stewart, R, and Thomas, L, 2005. Conference Report: Expanded ARV Treatment in the Free State: Sharing Experiences. University of the Free State, Bloemfontein South Africa 30 March – 01 April.

¹¹ JCSMF. 2005. Report on the 5th JCSMF Meeting held on the 29 August. Khayelitsha – Cape Town.

¹² Doherty, J, Loveday, M, Stewart, R, and Thomas, L, 2005. Conference Report: Expanded ARV Treatment in the Free State: Sharing Experiences. University of the Free State, Bloemfontein South Africa 30 March – 01 April.

¹³ Health Systems Trust. 2005. Conference Report: “Implementing the Comprehensive Care and Treatment Programme for HIV and AIDS patients in the Free State: Sharing experiences.” University of the Free State, Bloemfontein, South Africa.

¹⁴ Ibid.

6. Capacity issues: Human resource planning and management

The Department of Health agrees that “effective delivery of the Operational Plan depends on the availability of adequate numbers of appropriately trained doctors, pharmacists, nutritionists/ dieticians, professional nurses and counsellors at the service points.”¹⁵ The Human Resources for Health Plan (HRHP) 2005¹⁶ also acknowledges the department’s constitutional mandate to deliver health services with sufficient human resources for quality health care services. Unfortunately, as mentioned before, the human resource needs have been an ongoing challenge to effective rollout of the Operational Plan and other health services.

The World Health Organisation (2006) report revealed that “37 percent of doctors trained in South Africa are working in either Australia, Canada, Finland, France, Germany, Portugal, the United Kingdom or America. South African trained nurses working in these countries made up 13 496 of the local workforce of 184 459.”¹⁷ This report also revealed that about 35 000 qualified and registered nurses in South Africa are either inactive or unemployed despite 32 000 nursing vacancies in the health sector. Some of the 35 000 nurses are “thought to be working in non-nursing occupations”.¹⁸

Thus, the Department of Health proposes a number of strategies to facilitate the recruitment and retention of more health professionals to the public health service. These include improvement of conditions of service, remuneration, placement for community service, increased number of health professionals trained at health education institutions, increased scarce skills and rural allowances, overtime payments, and recruitment of foreign health professionals through government-to-government agreements.¹⁹

Ironically, the Operational Plan called for “significant additional investments to improve the capacity and capabilities of the national health care system, in particular the strengthening of human resource capacity, and providing incentives to recruit and retain health professionals in historically underserved areas.”²⁰ This is yet to be realized as human resource shortfalls continue to cripple adequate rollout of ARV treatment in the public sector. In addition, the Operational Plan sought to ensure “good coordination at national [and] provincial [levels with regard] to human resources, training, laboratory services, services, drug procurement, and information systems.”²¹

¹⁵ Department of Health. 2004. Monitoring and Evaluation Framework for the Comprehensive HIV and AIDS Care, Management and Treatment Programme for South Africa. September. Available from www.doh.gov.za (last accessed on 25 January 2006).

¹⁶ Department of Health. 2005. The Human Resources for Health Plan 2005. Available from <http://www.doh.gov.za/docs/discuss/hr2005/main.html> (last accessed on 26 January 2006)

¹⁷ Thom, A. 2006. “Dire health-worker shortage”. *Health-e News*, 7 April. Available from <http://www.health-e.org.za/news/article.php?uid=20031406> (last accessed on 11 April 2006).

¹⁸ Ibid.

¹⁹ Department of Health. 2005. “Taking stock of Human Resources for Health”. 9 January. Available from <http://www.doh.gov.za/docs/pr/pr0109-f.html> (last accessed on 26 January 2006)

²⁰ Department of Health. 2003. Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. (Pretoria: RSA).

²¹ Ibid.

“The prevalence of HIV and the roll out of ARVs has resulted in clinics becoming clogged up as new patient numbers and routine visits have increased.”²² That is, HIV and AIDS related needs have far outweighed the capacity of the government to respond to and deal with the impact of the pandemic. To support the implementation of the new human resources plan, the department has also proposed to re-vitalise the Community Health Workers (CHWs) ‘as an integral part of the decentralised health services’, ‘given the dramatic increase in need for chronic and palliative care’.²³

The stress of working with people who were sick was shown to have impacted negatively on health workers and their capacity to sustain the effort and enthusiasm. Although counsellors had been provided to help the health workers to debrief, this service was not available when needed. In addition to increasing the scale of psycho-social support to the health workers from within the health service [sector] other suggestions were made. Faith-based organisations were identified as having the potential to provide on an ongoing basis support to their members who are working as front line providers [of] HIV and AIDS [services]. This is an issue that requires partnerships and ongoing monitoring to help frontline providers cope with the ongoing stresses of the job. (Doherty et al, 2005)

In addition, viral load and CD4 count tests required to determine when treatment can be started also demand an increased capacity of the National Health Laboratory Services (NHLS) to absorb the demands of testing and information management. This indicates that capacity issues are not only limited to human resources and management, but also to the technical capacity of medical and information systems to cater for the demands.

The Department of Health recently (7 April 2006) launched its Human Resources for Health Plan (HRHP) 2005: “The main focus [of the plan] is on human resource planning, development and management including other strategic matters like stewardship for health, production of health professionals, international efforts to managing migration, etc. The plan also provides a framework within which all stakeholders can contribute to addressing these challenges individually or in partnership with the government.”²⁴ This plan has long been awaited and its urgent implementation would be greatly commended if it is reasonable and based on wide consultation with various stakeholders directly and indirectly impacted upon by the HIV and AIDS epidemic.

The activities under the new human resource plan do not sound like new initiatives. However the government needs to intensify its investment in human resources to ensure effective absorptive capacity for financial resources pumped into HIV and AIDS programmes. A plan to employ, deploy and accredit VCT counselors is necessary in order to reduce the burden on doctors and nurses in their day to day management of patients living with HIV and AIDS. Launching of the HRHP 2005 should be hastily

²² Doherty, J, Loveday, M, Stewart, R, and Thomas, L, 2005. Conference Report: Expanded ARV Treatment in the Free State: Sharing Experiences. University of the Free State, Bloemfontein South Africa 30 March – 01 April.

²³ Department of Health. 2005. The Human Resources for Health Plan 2005, pages 31 and 37. Available from <http://www.doh.gov.za/docs/discuss/hr2005/main.html> (last accessed on 26 January 2006)

²⁴ Department of Health. 2005. “Taking stock of Human Resources for Health”. 9 January. Available from <http://www.doh.gov.za/docs/pr/pr0109-f.html> (last accessed on 26 January 2006)

followed by urgent implementation to overcome challenges currently crippling the speed and effectiveness of health programmes including the ARV rollout.

7. Nutritional issues

It is common knowledge that medical treatments require nutritional support for them to be effective. Nutritional supplements are even more important among people living with HIV and AIDS because they boost the general functioning of the immune system. However, neither nutrition nor ARV treatment are self-sufficient – both need to be provided simultaneously to improve the health of people living with the disease. The Department of Health must ensure that ARV provision is supported with sufficient and appropriate nutritional supplements in a sustainable manner.

The 4th JCSMF Meeting held in Nelspruit (20 May 2005) clarified some of the issues around AIDS and nutrition and examined the extent to which government is not meeting the nutritional requirements of poor people in South Africa. In line with its commitments in the Comprehensive Plan and with its constitutional duties, the Department of Health must take measures to ensure that “everyone has the right to have access to sufficient food and water” and that a child’s right to “basic nutrition” is fulfilled.

It is widely accepted that there is a lack of sufficient food security in South Africa and that there are high levels of unemployment and poverty. Against this background, the JCSMF recognises that it will be difficult to implement an integrated nutritional programme without simultaneously addressing the causes of poor nutrition. The government of South Africa has plans of providing nutrition to the needy; however, the extent to which the nutritional support services actually reach those who need them remains questionable. The National Emergency Food Programme (NEFP) is aimed at fighting food insecurity. The Nutrition Supplementation Intervention for people living with TB and HIV seeks to provide supplement meals and micronutrients. In addition, according to the Operational Plan, the Department of Health is responsible for coordinating interdepartmental nutritional programmes and developing nutritional training materials.²⁵

The Operational Plan sets out the health policy on nutrition and in particular states, *inter alia*, that the plan is to target communities by giving them general information on nutrition with emphasis on HIV and AIDS related needs. It also states that Government seeks to put into practice a comprehensive nutritional programme with the introduction of HIV and AIDS care and treatment - with policies and strategies aimed at reducing poverty. More specifically, the HIV and AIDS care and treatment programme seeks to provide food supplements for all people living with clinical AIDS who are malnourished and eligible for ARVs and who do not have access to food supply. Furthermore, individuals seeking AIDS treatment at service points should receive counseling and materials on healthy eating and food preparation.

Health-e News has constantly reported on ARV treatment provision and nutrition with special interest on the operations of the Rath Foundation in South Africa.²⁶ The Rath

²⁵ Department of Health. 2003. Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. (Pretoria: RSA).

²⁶ Health-e News (Online). Articles available from <http://health-e.co.za/news/>

Foundation's operations have reportedly been 'perceived' to be supported by the Minister of Health Manto Tshabalala-Msimang²⁷ who emphasizes the importance of nutrition more than the use of ARVs by people living with HIV and AIDS. The Minister has openly challenged the efficacy and safety of the ARV drugs, indicating that they would cause more harm than benefits to those who use them.^{28, 29} This has somewhat created confusion, and allowed people, for example, the Rath Foundation, to take advantage of the situation and promote their nutrition-based interventions, at the expense of ARV treatment.³⁰

Ian Hodgson of Open Democracy best described Rath's motives: "***In a country where the demand for ARVs outstrips supply by a factor of four, news of an alternative is for some miraculous.***"³¹ Hodgson (2006) critically emphasized that "*a policy that implicitly supports a nutritional alternative to ARVs could distract attention from the appalling lack of progress in access to AIDS medications. The roll-out of ARVs in South Africa is painfully slow: this is the wealthiest and one of the most stable nations on the continent, yet of the 840,000 people who require ARVs, estimates for the end of 2005 suggest that only around 200,000 (up from 104,000 in September 2004) [had] access.*"³²

Further, Itano (2005) argued that "in the aftermath of debates about the affordability and efficacy of universal ARV programmes, any emphasis on nutrition has been dismissed as an excuse for not doing more."³³

The provision of HAART in itself is not sufficient as there are a variety of other socio-economic variables that impact on successful treatment of HIV and AIDS. The WHO protocol for the use of ARVs includes: HIV counselling and testing and follow-up counselling services to ensure psychosocial support and adherence to treatment; capacity to appropriately manage HIV-related illness and opportunistic infections; a laboratory that provides tests for monitoring treatment; a continuous supply of anti-retrovirals and medicines for the treatment of opportunistic infections and other HIV-related illnesses; reliable regulatory mechanisms. Countries implementing HAART programmes are also required to concurrently implement an HIV and AIDS drug resistance sentinel surveillance system. This implies the availability of adequately trained doctors,

²⁷ Health-e News. 2005. "TAC on Rath". *Health-e News*, 4 November. Available from <http://www.health-e.org.za/news/article.php?uid=20031327>. (last accessed on 10 April 2006).

²⁸ Cullinan, K. & Reid, L. 2005. "Patients fear anti-retroviral drugs". *Health-e News*, 10 August. Available from <http://www.health-e.org.za/news/article.php?uid=20031287>. (last accessed 12 April 2006).

²⁹ Cullinan, K. 2005. "Health Minister promotes nutritional alternative to ARV roll-out". *Health-e News*, 30 May. Available from <http://www.health-e.org.za/news/article.php?uid=20031252>. (last accessed 12 April 2006).

³⁰ Thom, A. 2005. "TAC and doctors challenge Manto and Rath in court". *Health-e News*, 30 November. Available from <http://www.health-e.org.za/news/article.php?uid=20031334>. (last accessed on 12 April 2006).

³¹ Hodgson, I. 2006. "Dazed and confused: the reality of AIDS treatment in South Africa". 11 January. Available from http://www.opendemocracy.net/globalization-hiv/southafrica_3170.jsp (last accessed on 26 January 2006).

³² Ibid.

³³ Itano, N. 2005. "SPECIAL FEATURE: Benefits of Nutrition Neglected In the Fight against AIDS". 10 March. The South African Institute of International Affairs: Braamfontein. Available from <http://www.saiia.org.za/modules.php?op=modload&name=News&file=article&sid=544> (last accessed on 26 January 2006).

clinical officers, nurses, laboratory technicians, pharmacists, counsellors and clerks to provide the services required. (Ntuli et al, 2003)³⁴

Idasa, through the 4th JCSMF meeting, noted that the nutrition portion of the HIV and AIDS conditional grant for the Operational Plan cannot be assessed since reporting on the budget is not disaggregated.

The Forum also recognised serious gaps in the nutrition support programme at facility level. These include a shortage of social workers and nutritionists in the country, lack of proper guidelines, inadequate resources and poor supervision. This, coupled with logistical delays in getting food parcels to facilities, adds to the weakness of the programme. Therefore, in line with the new HRHP 2005, adequate personnel and delivery systems are required to ensure that food parcels are delivered to those who need them and that the contents are in a healthy condition.

8. Public Private Partnerships (PPPs)

Given the scarcity of resources in the public sector, especially informational and human resources, it would make sense for the government to develop close and strong partnerships with the private sector to respond to the shortage of skills and other resources. Government needs to develop creative models to effectively encourage private sector partnerships to assist with expanding public sector capacity. The private sector report made at the 2nd JCSMF Meeting in Bloemfontein (19 November 2004) warned that insufficient attention is being directed at the provision of treatment in the public sector for dependants of employees who are accessing treatment through their workplace treatment programmes. The private sector is reportedly working with donors to address this problem.³⁵

The JCSMF recommended that both the public and private sectors urgently develop stronger operational ties that would facilitate collaboration and create forum for discussion. There is a need to create innovative and mutually beneficial public-private partnerships. The forum recommends that the private sector must continue to assist with the implementation of the Operational Plan by offering human and other resources, as well as training and administrative support to public facilities.³⁶ In addition, civil society organizations should also support the joint efforts by implementing and utilizing resources mobilized through public-private partnerships.

9. Roles of the development aid partners

The JCSMF recognised that were it not for the work of some donors, the government would not have been able to reach the approximately 86 000 patients who were on

³⁴ Ntuli, A, Ijumba, P, McCoy, D, Padarath, A and Berthiaume, L. 2003. HIV AND AIDS and Health Sector Responses in South Africa Treatment Access and Equity: Balancing the Act. Health Systems Trust, September. Available from <http://hst.org.za/uploads/files/equinet7.pdf> (last accessed on 26 January 2006).

³⁵ JCSMF. 2004. Resolutions of the Bloemfontein meeting held on the 19 November/ 2nd Meeting Resolutions. Government Hall – Bloemfontein.

³⁶ Ibid.

treatment by November 2005. The Forum was thankful to the donors for their important contribution to improving health.

At the 6th JCSMF meeting (15 November 2005), it was revealed that even though donors are supporting public health facilities as well as other government departments with technical and other support – they nevertheless continue to experience long delays in executing Memorandums of Understanding (MOUs) with these government departments.

Donors reported that in the absence of a national management information system, it is difficult to collect accurate and proper data on key indicators for the ARV programme. Notably, donors who have individually collected data regarding their own programmes, report excellent outcomes for patients on treatment (including children). Such donors include PEPFAR, Absolute Return for Children (ARK) and Medecins Sans Frontieres (MSF). “Donors also indicated that at times there are poor response levels from government [which is best] described by ‘We will call you!’ Further, the public sector seems to be very suspicious of the help being offered by donors and often demands control mechanisms that are slow and inevitably fruitless.”³⁷

At the 6th JCSMF workshop held in East London, donors requested assistance and intervention from the Forum and the national Department of Health to resolve provincial and municipal conflicts that affect the delivery of child health services especially in the Western Cape. The donors also recommended that the departments of Home Affairs, Health, and the Health Professions Council of South Africa (HPCSA) should fast-track foreign health care workers’ registration especially in provinces where attempts are being made to redress the human resource crisis in the short term. In addition, donors also encouraged civil society and the health sector to ensure that the ARV programme eventually becomes nurse driven and not hospital based, for quicker access and better response. More importantly, donors motivated for an increase in the number of children on ARV treatment and called on drug companies to make easier and simpler drug regimens for children.

IV. Concluding statement

The JCSMF is keen on seeing its resolutions made at its quarterly meetings adopted by all stakeholders, including national and provincial governments, donors, the private sector and civil society organisations, to expedite effective rollout of the ARV programme in South Africa. The Forum is committing itself to work with and support the Department of Health in any way possible to rollout and monitor the delivery of ARV treatment to those who need it.

³⁷ JCSMF. 2005. “Resolutions of the 6th Meeting of the JCSMF”. 14 November. East London – Eastern Cape.



Department of
Social Development

This project was funded by the Foreign Assistance Agencies of Australia (AusAID), the UK (DFID), and the United States of America (USAID), and by the United Nations Development Programme (UNDP) of South Africa. The management and technical assistance was provided by the Joint Economics AIDS and Poverty Programme (JEAPP), which is affiliated to the African Asian Society (AAS).



Australian Government
AusAID



USAID
FROM THE AMERICAN PEOPLE

