

NSP REVIEW

Engaging with South Africa's National Strategic Plan for HIV, STIs and TB | Edition 8 | September – November 2013

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THE NSP: DO WE KNOW WHAT'S HAPPENING?

Monitoring the NSP
Slow progress at SANAC
The NHI pilot programme
Assessing the first 18 months

Why are there no medicines at the clinic?
The underlying causes of medicine stock-outs
Community activism
A tale of three Eastern Cape clinics

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This is the eighth issue of NSP Review. We aim to provide quality analysis and monitoring of the implementation of the new NSP. It is our hope that this publication will increase awareness of, and critical engagement with, the NSP. We will try to keep it relevant with evidence from new research and feedback from the various district offices of the Treatment Action Campaign as well as organisations with which we work closely. Our vision is a vibrant, evidence-based publication that will help all stakeholders drive a more successful response to HIV, STIs and TB. We encourage you to get in touch with us should you want to contribute to future editions of NSP Review. You can e-mail the editor at nsp@tac.org.za.

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Cover photo: Adherence clubs for HIV-positive patients have been successful in strengthening their treatment, adherence and outcomes. Photo by Samantha Reinders, courtesy of Médecins Sans Frontières.

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EDITORIAL



Photo by Julie Remy, courtesy of Médecins Sans Frontières

"What gets measured gets done." This is arguably the most important thing Margaret Chan, Director-General of the World Health Organisation, has ever said. Monitoring and evaluation is the map that should guide all actors in the healthcare system. As Ben Gaunt puts it: *"Managing the health system without information is like trying to fly a plane blind."* And for government, reporting health information is also about accountability. How is the department of health spending taxpayer's money and what has it achieved?

This issue of NSP Review takes a hard, honest look at what is getting measured in South Africa's National Strategic Plan for HIV, STIs and TB. It describes how little we know about the country's current progress toward achieving the goals of the NSP. The health system's routine data collection system is generally weak, contains too many indicators and produces information that is often unreliable. The roll-out of the electronic antiretroviral register (the famous TIER.net e-register) to 2200 facilities across the country is encouraging, and so is the futuristic vision of the National Health Insurance where every patient will have a health 'smart card' feeding into a national electronic system.

There are, however, many obstacles to overcome and much more investment into monitoring and evaluation is required in order to move beyond rhetoric to real-world implementation. For example, the unit tasked with monitoring and evaluation at the South African National AIDS Council (SANAC) is understaffed, and is yet to produce a first progress report on the NSP 2012-2016, whilst the list of indicators still needs to be finalised. The failure to achieve significant improvements in neglected NHI pilot districts adds to these concerns, as does the neglect of Eastern Cape rural clinics described by Anso Thom. The vicious cycle of *rubbish-in rubbish-out* needs to be broken. When reports are not fed back to clinic level, many health workers

do not see the benefit of data collection and hence don't prioritise accurate record keeping, which in turn leads to poor quality reporting, which further enhances the perception that it is useless.

As Francois Venter puts it, when it comes to indicators, *less is more*; investing in the collection of a limited number of critical indicators will allow us to better understand what is happening and what is needed to improve the programme. To monitor the cascade from HIV testing to retention in care, we need to know numbers tested, linked to care, CD4 counts, initiations on ART, retention in care and viral load suppression per year on ART.

There are undeniable successes: more than 2.5 million people started on ART and a decrease in mother to child transmission below 3%. Yet, these achievements are fragile and there are worrying signs such as increasing drug stockouts, the reversal of nurse-initiated management of ART in some areas, ongoing high transmission rates, and the failure to adequately support key population groups such as migrants, men who have sex with men and drug users. And key information on the programme is missing. How many patients are still in care? How many of the ones in care have an undetectable viral load? Helen Schneider and Wim Van Damme argue that to enhance the response to the epidemic, there is a need to better integrate the information produced by the public health system, researchers and civil society. For this, increased transparency and dialogue is necessary.

In the end, what we measure (the indicators) and how well we measure it (the quality) tells us about how much we really care about what we do. Yet as my friend Ernest Nyamato puts it, 'In M&E we only think about teaching people how to seed, but they also need to harvest and learn to cook'.

Gilles van Cutsem, Medical Coordinator for Médecins Sans Frontières in South Africa



Photo by Samantha Reinders, courtesy of Médecins Sans Frontières

SLOW PROGRESS AT SANAC

By Mara Kardas-Nelson and Marcus Low

The National Strategic Plan lists the HIV and TB-related targets that South Africa aims to achieve by 2016. But more than a year into the latest NSP, we still have little idea about whether the country is on track to meet these goals. To complicate matters, within the South African National AIDS Council (SANAC), the unit tasked with monitoring progress is understaffed and is only now getting off the ground.

WHAT ARE WE MONITORING? A THREE TIER SYSTEM

South Africa monitors a wide range of health indicators but the information that is used is often unreliable. There are many reasons for this weakness. Our country relies mostly on paper-based systems and data gathering is often done by overburdened healthcare workers. When information is compiled at the health facility level it is forwarded to others at the district and provincial levels before, finally, reaching the national Department of Health. In systems like this there is potential for errors and delays, for the loss of files, and the double counting of data. Official health data and statistics may therefore not be an accurate reflection of what is happening on the ground. In addition, not all health centres collect the same data, and a comprehensive national picture of health burdens is difficult to establish.

Collecting data is useful but not all indicators are relevant or helpful to providing healthcare. Some even argue that South Africa may have too many indicators. Primary healthcare measurements, for example, of how many patients are seen at particular clinics are useful in theory but are vulnerable to human error, and do not reflect the quality of care. Requiring healthcare workers to record many indicators burdens them with further demands. It may degrade the quality of the reporting, and may even reduce the time already-stressed health workers have to care for patients.

The Department of Health decides what data are to be collected and how this is done. Data are currently gathered via three different systems, or tiers. The first tier is a paper-based system, used in the majority of the country's health facilities. The second tier is an electronic antiretroviral therapy (ART) register, currently used at 1,600 facilities. The third tier is an electronic health register that captures all available health information. This third form of data gathering is currently used at only 30 facilities.

Dr Yogan Pillay of South Africa's Department of Health says that the comprehensive tier-three system will be rolled out across the country as part of the new National Health Insurance (NHI) system. By using a patient 'smart card', which will look like a credit card and hold all patient information electronically, data will be automatically uploaded into a national electronic system, making data centralized, and therefore more easily accessible and accurate. This will mean that patient information can be more easily transferred from facility to facility, as needed.

But Pillay says there are challenges to implementing this system. Tier-three relies on the availability of computers at every facility—problematic given that some rural facilities do not even have electricity, and staff need training in how to collect the data.

KEEPING TRACK OF SANAC

While South Africa has many health goals to aspire to, those concerning HIV and TB are outlined in the country's National Strategic Plan for HIV/AIDS, STIs and TB, otherwise known as the NSP. While these goals are laudable, they are not always well defined. This has made the country's success harder to track, says Dr Nevilene Slingers of the South African National AIDS Council (SANAC), an organisation responsible for monitoring the implementation of the Plan. Some of the concepts that are used in the NSP are difficult to quantify: how, for example, does one measure stigma? The targets of the NSP have also only been set within a five-year timeframe; and no guidance has been given about exactly what should be achieved in each year.

The NSP includes a 'Comprehensive M&E Framework' which can be used to define a set of sub-indicators and enable progress to be tracked. But more than a year into the current NSP, this framework has not been clarified or implemented, and SANAC's team responsible for M&E remains small. At the time of writing, it consisted of Dr Fareed Abdullah, SANAC's CEO, and a Senior Manager: NSP Implementation. A promised annual progress report has not yet been released.

STILL NO FINAL INDICATORS

While some indicators, such as treatment goals, are already measured on an ongoing basis by the Department of Health, far less baseline information is available for non-biomedical targets. For

example, prior to SANAC's recent release of the first comprehensive count of sex workers in South Africa (an estimate of 153,000 people), almost no accurate information about sex workers was available, even though this group is identified as a key vulnerable population in the NSP. Abdullah says that technical task teams have been set up to determine indicators for non-biomedical areas. Government departments, development agencies, and all sectors of civil society will provide input.

Historical and organisational problems have contributed to delays in SANAC's monitoring and

evaluation of the NSP. As Slingers notes, it has taken time for SANAC to design its structures and appoint staff. She observes: "You can't have any M&E plan until you have [these arrangements] in place." But Abdullah says he acknowledges "that SANAC has not made enough progress in [M&E]" and adds that "this [problem] has already been identified as a priority for the Secretariat for the current year."

Abdullah says that a final list of M&E indicators will be determined by SANAC's Programme Review Committee in "the coming months", and expects publication of the first annual report by September. Slingers and Abdullah note that South Africa's proposal to the Global Fund could act as a guide for further defining the M&E indicators and annual targets.

"What we are expecting to do is to select the most important indicators and targets which will capture 80% of the NSP, and we hope to report on that

Historical and organisational problems have contributed to delays in monitoring and evaluation of the NSP by SANAC.





annually,” says Abdullah. “We might be late with our first annual report but there will be a report every year, and a proper mid-term evaluation.” SANAC will rely on the mid-term evaluation to determine whether the NSP targets are being achieved, and if any indicators will need to be reconsidered.

SANAC will consider data from government departments, gathered as part of annual performance monitoring and evaluation, for its annual and mid-term reviews. Data issued by provincial AIDS councils, donors, and published in research literature will also contribute to monitoring progress.

“In general,” comments Abdullah, “we think we should draw from secondary sources. There are one or two programmes for which we think we might [need] ... our own system of data collection, like the national sex worker programme ... because we don’t believe ... anybody’s actually collecting that data in a systematic, unified way.”

While acknowledging the slow progress of SANAC’s M&E programmes, Abdullah is hopeful. He points to the M&E framework developed for the Global Fund, and a report issued by SANAC for UNAIDS which details the country’s progress towards meeting UN-defined goals. “We’re taking important first steps,” he says.

Mara Kardas-Nelson is a journalist with the Mail & Guardian’s Centre for Health Journalism. Marcus Low is joint editor of the NSP Review and editor of Equal Treatment magazine.

Left: SANAC CEO, Fareed Abdullah, chatting to some of his colleagues. Photo by Masi Losi, courtesy of the Treatment Action Campaign Archive

MONITORING AND EVALUATION: WHEN LESS INFORMATION CAN TELL US MORE

“Monitoring and evaluation (M&E) is a complicated field,” says Professor Francois Venter, Deputy Executive Director of the Wits Reproductive Health and HIV Institute. Many people, he suggests, seem intent on measuring everything, but doing so makes no sense.

“The World Health Organization in the past has put out documents with over 80 data fields ... The Department of Health [in] Gauteng Province ... translated it into a ... form that had to be filled out for every single patient,” he says. “This [was] unrealistic and quickly discarded ... There is no way a health worker can afford to spend 30 minutes on filling out a form for every single patient.”

Most experts we spoke to agreed. Venter argues that it would make more sense to collect data on fewer critical indicators and to make sure that this is done well. We can learn more from higher-quality data.

Better critical indicators will help us to get a deeper understanding of what is happening at the district healthcare level. “For example,” he says, “what does it tell us if patients are recorded as being initiated at a low CD4 count? Does it not tell us more if we [know] ... how many are being retained on treatment at one year or two years? If [the answer] is 80-90% [of patients], we know we are doing a good job. If it is 50%, [this] is not good.”

Similarly, knowing viral load suppression rates for patients at the facility level can tell us a lot about the quality of the treatment people are receiving. If viral loads are suppressed in 90% of patients, he adds, we can tell that a facility is doing a good job.



Photo by Samantha Reinders, courtesy of Medecins Sans Frontières

FLYING BLIND

By Ben Gaunt

A senior manager from South Africa's Department of Health once said that managing a healthcare system without having enough information is "like trying to fly a plane blind". Numbers and statistics can seem dry and boring, but having good data is critical when managing health systems. Ben Gaunt, a rural doctor, shares his perspective about trying to improve clinical care.

Why collect data?

Data collection takes time and money. So why do we do it? If systems are to function well, good data are essential. Health facilities need accurate figures to make sure that budgets are done correctly, that drug supply chains work, and that we make the most of the staff and facilities we have.

South Africa has thousands of clinics but its resources are limited. Good data reporting is important to national healthcare planning and keeping control of costs. But at the clinic level, accurate data reporting offers more immediate benefits. The purpose of tracking patients' viral loads over time, for example, is to help us to improve clinical care both for individuals and communities.

Data collection must have a clear purpose and it must make things better for patients. We need to pay greater attention to feedback loops to help us improve the quality of our data. Evaluations of data quality can be done via informal analysis or more structured audits. However, clinic supervisors are often more focused on maintaining data registers than they are on receiving feedback about data quality. If we want meaningful data, we need to instill a respect for data accuracy and a clear understanding of why we gather data.

What data are we collecting?

Because data collection is costly, we need to ensure that we collect the right information. We can do this by looking closely at the purpose of the data. Is a particular set of data, for example, going to improve service delivery? South Africa's District Health Information System requires staff to complete multiple data fields, but most nurses and clinicians find it overwhelming. Recording data badly about 100 parameters isn't nearly as helpful as collecting 10 pieces of information really well. In fact, inaccurate or incomplete data can be *harmful* to patients and to health systems in general.

The monitoring of South Africa's antiretroviral treatment (ART) programme focuses on access to care. This approach was critically important in the early years of the ART rollout. But now that more and more people are on treatment, are we ignoring quality-of-care indicators at our peril? How many sites are accurately reporting the number of patients who have had their annual viral load measured according to schedule, or the proportion of patients with viral load suppression?

Who collects the data?

In South Africa, the process of collecting data can be challenging: demand for healthcare is high and nurses are busy. Not all clinics have a data capturer yet. Many of those responsible for capturing data have a poor understanding of the health sector. Supervisor visits to some clinics [may] occur only monthly. In addition, many of those in charge place too much emphasis on numbers instead of what data can tell us about the quality of the clinical care that's being given.

Poor maths education also impacts on data accuracy. Many data capturers and nurses lack analytical skills and feel uncomfortable when dealing with numbers and statistics. At one clinic, a vitamin A coverage rate of 290% was reported. In other instances, percentages of a whole have not added up to 100. These are basic and unacceptable mistakes.

How do we collect data?

Perhaps one of the biggest obstacles to generating good data in our country is how we collect these figures. Clinics still rely largely on paper-based

data gathering. It is easy to see why this is still happening: paper-based systems are simple and don't rely on expensive hardware. They also do not require additional staff training, they don't depend on electricity, and their maintenance and running costs are low.

When we implement new kinds of information technology, we should be careful that we do not simply generate an electronic version of what we have already. Many electronic systems, just like our current paper-based system, are designed simply to collect statistics rather than analyse them. Few are able to track patients moving to different areas of the healthcare system. What we need is an awareness of the connection between the data we generate and the clinical care we give. The value of any electronic system depends entirely on whether it lets us meaningfully analyse the data we have.

Ideally, each health facility needs a data champion: someone who understands how data feedback works and how to improve clinical care. Someone who can mentor others about the value of good, accurate data.

The right attitude

We need to improve South Africa's data systems. But we also need to improve the *quality* of the data we collect. It is important that the Department of Health recognises the gaps and flaws in our current system and does this with constructive support from members of civil society and the media. Improvements in data quality are critical and will help significantly in our fight to provide better healthcare.

Ben Gaunt is a medical doctor working in the Eastern Cape who is passionate about providing high-quality care to rural communities. In 2013, he received a Rural Doctor of the Year Award from RuDASA (the Rural Doctors Association of South Africa).

Photo by Darren Taylor





Photo courtesy of KZN Media

We know a good deal about HIV in South Africa, but are we using and sharing this knowledge effectively?

TURNING RESEARCH INTO ACTION:

NEW CHALLENGES IN THE FIGHT AGAINST HIV

WHERE ARE WE NOW?

The atmosphere was upbeat at the South African AIDS Conference in Durban this year, and with good reason. Recent data on HIV in South Africa indicate the undeniable success of the National Strategic Plan and reflect a phase of strong leadership in the battle against the HIV/AIDS epidemic. There are good reasons to be positive: over two million people are now on antiretroviral therapy (ART), mother-to-child transmission has been reduced from 15% to less than 3%, and median life expectancy has increased sharply. Although some people claim these positive indicators may be overly optimistic or biased, the achievements are impressive and have led us into a new phase of controlling and managing the HIV epidemic in our country.

But successes bring new challenges, such as how to retain patients in the increasing number of long-term ART cohort studies and how to manage complex comorbidities. The goal of eliminating mother-to-child transmission of HIV may be even more difficult to achieve than the progress made so far. New controversies also need to be debated, such as which treatment protocols (Option B or B+) to adopt in treatment guidelines for the prevention of mother-to-child transmission (PMTCT).

Crucially, the successes of the ART scale-up and of the scale-up of PMTCT have depended on a combination of a reliable supply of medicines and the efficient use of human resources. Distressingly frequent reports of drug shortages in most provinces, however, and instances of the reversal of nurse-initiated and managed antiretroviral treatment (NIMART) practices suggests that the progress is vulnerable.

These are signs that the achievements of the NSP remain fragile and that the sustainability of the NSP is not assured. We have failed to gain control of HIV prevention in South Africa. While the sexual transmission of HIV is beginning to decline, the infection rate in our country remains among the highest in the world and incidence rates of HIV in young women are also still alarmingly high. Further gaps remain in the support provided to key population groups, such as migrants, men who have sex with men, and drug users.

South Africa's response to the HIV epidemic is at an important threshold. We know a lot now about the HIV epidemic and the NSP in South Africa. But are the data, knowledge and insights generated so far sufficient to monitor and evaluate the NSP,

or to address the challenges facing our responses to the HIV epidemic in South Africa? And are our monitoring and evaluation (M&E) efforts adequate or fit for purpose?

HOW CAN WE KNOW OUR EPIDEMIC BETTER?

UNAIDS has called on nations to "know your epidemic". While South Africa has fulfilled the basic requirements of doing so, a meaningful M&E strategy for the NSP needs to push beyond the boundaries of our current knowledge. This requires making sense of a wider range of available data and information, and building a more sophisticated process for identifying and selecting sources of knowledge about HIV and the NSP. This will help to create a more complex picture of South Africa's evolving and diverse circumstances.

What we already know about HIV and health in South Africa is based on a wide variety of sources which have helped us to understand the HIV epidemic better and to develop better responses to it.



Photo by Samantha Reinders, courtesy of Médecins Sans Frontières

These sources have included: routine data provided by the health services (for example, which groups of people are receiving ART), data from specific surveillance efforts (such as the prevalence of HIV among pregnant women at surveillance sites), data from scientific studies (such as life expectancy levels recorded at demographic surveillance sites), data on mortality from death registrations, and data from civil society actors (for example, levels of medicine stock-outs and staff absenteeism). Information typically comes from formal sources (usually documented) and informal sources (often verbal). It may take the form of clear and explicit knowledge, or the information may be implicit or tacit.

Each of these forms of data is valuable but may have weaknesses. Some may be more or less reliable or biased, or may be seen as more or less representative. In instances in which no reliable information is available, some evidence may simply be anecdotal. Other forms of management information, such as details about the supply and dispensing of ART medicines, are collected but rarely collated. Access to particular types of information, such as audits on budgets and human resources, may be restricted. When data are examined, interpretations may also depend on the perspectives of the researchers. The accessibility of data, the importance given to particular kinds of data, and researcher perceptions of knowledge gaps and uncertainties may also affect interpretation.

With the inputs available to us, we have applied a scientific framework of interpretation to build on our knowledge of the HIV epidemic and the state of the NSP's implementation. Comparing, contrasting and verifying information using this approach have helped us to clarify the certainties and uncertainties about information related to the epidemic. This has aided debates about both HIV and the NSP.

By examining and interpreting the data within specific contexts, we have gained insight into the reality of HIV in South Africa and the future of the epidemic. As our understanding has deepened, we have also begun to ask more questions. This is because the process of enquiry never ends: each study or report raises new questions. Often these require more investigation, more information, and further studies. Academics, when asked for definitive answers often claim that "more research is needed".

But does research and investigation lead to more decisive and better action? Or does it lead us to a state of information overload – to "paralysis by analysis"?

DO WE REALLY KNOW ENOUGH?

HIV, especially in South Africa, has been studied extensively. However, there are still important frontiers of science to be explored in relation to the epidemic. It is important to recognise that the quantity of available information is so large that no single person can possibly review it all. The information and insights which are already available continue to help us to improve the implementation of the NSP and its adaptation. What is critical now is that we *share* and discuss our interpretations of the state of the NSP. We must utilise relevant information and data from all available sources, including routine M&E, civil society information, feedback from frontline providers and managers, information from academics, and from research sites – even if this information is incomplete, preliminary, partial and/or potentially biased.

To identify priority areas for action, we will need to analyse, interpret and compare data (even in instances when the findings are imperfect). Sound field knowledge and participatory processes will help us to interpret and compare information and epidemic trends. In this way, we will be able to compare, for example, information at the provincial, district and clinic level. Doing so will help us to identify areas of agreement and disagreement, as well as data weaknesses and other areas of concern.

Multi-stakeholder efforts will need to be transparent. Success will depend on gaining access to existing information, even when such information is deemed sensitive. The aim of these efforts should not be to accuse or scapegoat individuals or institutions. Instead, they should promote rapid learning, the sharing of good practices, the rapid identification of problems, and the implementation of swift corrective action. The learning processes inherent in programme rollouts and scaling-up will, of course, continue as further challenges reveal themselves.



Photo by Samantha Reinders, courtesy of Médecins Sans Frontières

WORKING TOGETHER

M&E activities in South Africa need to embrace and reflect the inclusive vision of the NSP. To understand fully the current phase of the HIV epidemic and to ensure that our responses are appropriate, we will require M&E systems that evolve, respond and adapt. It is also important that we involve multiple stakeholders: this will ensure the integration of different kinds of information, interpretations and perspectives into M&E processes. Members of the government, the academic community, civil society, health workers, health managers, and policymakers are among those who have an important role to play.

Responses to this phase of the HIV epidemic require the sharing of data and information and depend on more open dialogue and discussion. Doing this will build shared knowledge, better accountability, and more effective action.

Helen Schneider is the Director of the School of Public Health at the University of the Western Cape and Wim van Damme is the SARChI Professor in Health Systems, Complexity and Social Change at the School of Public Health at the University of the Western Cape and Professor of Public Health at the Antwerp Institute of Tropical Medicine.

ARE OFFICIAL ESTIMATES ACCURATE OF HOW MANY PEOPLE IN SOUTH AFRICA ARE ON ART?

By Leigh Johnson and Meg Osler

South Africa's antiretroviral treatment (ART) programme is one of the largest in the world. However, estimates of the number of patients receiving ART need to be improved. Some claim that official figures overestimate the number of patients on ART. But there are other arguments to suggest that the reported totals may underestimate how many are receiving treatment.

The rollout of free ART in South Africa began in 2004 after the government agreed to fund treatment through the country's public health service. Delivering ART requires organising drug procurement and distribution, formalising treatment

guidelines, and deciding on eligibility criteria. Clinicians have been trained and key indicators for monitoring the programme have also been defined. But standardised clinical records and registers have not been issued for recording and aggregating *precise* figures for enrolment and retention.

If clinics do not determine the precise level of programme attrition, the treatment totals they report may be inaccurate.

Most healthcare facilities use diaries to track patients who start ART. Clinic 'events' are recorded in tally sheets or log books. These events include deaths, patient transfers and patients

lost to care. The number of patients remaining in care at each facility is calculated for each month. This is done by subtracting the number of monthly events from the total number of patients who began ART at a facility.

If clinics do not determine the precise level of programme attrition, the treatment totals they report may be inaccurate. Migration between clinics is common: patients, for example, may move elsewhere or they may decide to go to another, new clinic closer to where they live. When patients refer themselves to other clinics, such changes often remain unregistered. This means that in some instances patients may appear in the treatment totals of two different clinics and therefore be counted twice.

Patients may decide to stop taking ART. Others may die. If such events are not recorded, patients will remain registered as 'receiving ART'. Although the Department of Health states that its treatment totals only include the number of patients currently on ART, many clinics still appear to be reporting the total number of patients they have ever enrolled (i.e. their cumulative treatment totals), instead of making adjustments for programme attrition.

To calculate the number of 'active' patients accurately, clinics usually deduct the number of patients who have not been seen in the last three months from the cumulative number of patients seen. The length of this cut-off period is arbitrary but may also bias the reported ART figures. If, for example, a substantial proportion



The morning drug burden for a patient in an inpatient MDR-TB treatment facility in Kwa-Zulu Natal. Photo by Amelia Rutter, courtesy of Photoshare

of patients seen in the last three months are no longer on ART, the reported totals will be overstated. But if a substantial proportion of the patients who have not been seen in the last three months *are* actually still on ART, the figures will be understated. Distortions may also be made worse by clerical errors or delays in the updating of patient registers. Choosing a shorter cut-off period would reduce the risk of over-statement but it would increase the risk of understatement.

An underestimation of patient numbers could also occur if clinics do not report their totals to provincial health departments on time. When this happens, previous totals may be carried forward to the next reporting cycle. Estimates of how many people are receiving ART may be similarly distorted at the provincial level: late submissions may mean that new national ART estimates are based on outdated figures.

Treatment totals reported by the Department of Health usually relate only to public sector ART programmes. Patients who receive ART through the private sector (either through medical schemes or workforce treatment programmes) are not included. Although most NGO ART programmes have been incorporated into the public sector, certain NGOs are still excluded. These exclusions from official Department of Health statistics mean that the official number of ART patients in South Africa may be an underestimate.

HOPE FOR IMPROVEMENT

South Africa's ART statistics have not always been reliable. But there is reason to hope that the quality of the data is improving. The introduction of standardised clinical records, for instance, and a new three-level M&E system (paper-based data gathering, electronic registers and networked software: see page 3) are helping to improve the accuracy of reporting. An intensive focus on monitoring and evaluation training, as well as new support and accountability measures will help us to improve the quality of the data available.

TIER.Net, a new electronic data collection system, is being implemented at over 2,200 facilities nationally. This software uses algorithms to accurately calculate the number of patients lost to care. The TIER.Net system makes it easier to access patients' demographic profile details and their clinical characteristics (such as baseline CD4 count distributions and viral load suppression). Completion and retention rates are also monitored. Clinics also use reports to identify which patients have missed appointments. Contact by cell phone or home visits may also be helping to improve retention rates.

If reporting and accountability measures improve, the data we have will be more accurate. This will help to improve resource allocation policies and improve the impact of ART interventions.

Leigh Johnson and Meg Osler work at the Centre for Infectious Disease Epidemiology and Research, University of Cape Town.

Kotyana Clinic has had solar panels for about three years, but they were never connected. The clinic has no electricity or running water. Photo by Thys Dullaart



THE NATIONAL HEALTH INSURANCE PILOT PROGRAMME: ASSESSING THE FIRST EIGHTEEN MONTHS

By Daygan Eagar and Thoko Madonko

A National Health Insurance (NHI) scheme is being piloted in South Africa. Close monitoring will help us decide whether it works and importantly if it will support the implementation of the NSP.

In August 2011 the Department of Health (DoH) published a Green Paper for a proposed National Health Insurance (NHI) scheme in South Africa. The primary goal of which is to “ensure that everyone has access to a defined comprehensive package of healthcare services.” As a result, any developments pertaining to NHI will be of importance to those monitoring the implementation of NSP. NHI should be seen as a key component of broader health reforms currently taking place in South Africa. For example, the new Office for Health Standards Compliance (OHSC) has begun the process of auditing health facilities in South Africa. Its findings will inform the work of the new Facility Improvement Teams and will aid the development of national norms and standards for ensuring quality of public health facilities. Public comment has also been invited.

While this work is encouraging, the new NHI plans have been criticised for their lack of clarity. This lack of clarity has a bearing on the implementation of the NSP. Precise details about the structure of the system, for example, and how it will function, remain unclear. Two years after the Green Paper was published, an anticipated government White Paper has still not been issued, and operational details remain opaque. How will the NHI administrative structure be organised? What role is envisaged for the private sector (as providers or funders)? What will the NHI actually cost, and who will provide this funding? For the OHSC to succeed, effective community participation is essential. But how the public will be engaged in the development of the NHI scheme remains unclear.

Redesigning the primary healthcare (PHC) system

Achieving universal healthcare coverage will depend on shifting the central focus of health service delivery from the tertiary hospital level to the community level. Particular emphasis must be placed on rural areas and on marginalised and vulnerable groups. A more equal distribution of skilled health workers is also important. At the district level, we need to ensure that there are enough doctors, nurses, specialists, and community health workers to deliver promotional, preventative, curative and rehabilitative services. To support a more comprehensive range of services, including those outlined in the NSP, primary healthcare delivery will need to be integrated, so that different levels within the healthcare system are able to support each other better. Newly-formed District

Specialist Teams have started this process by investigating how GPs will be contracted into providing support at PHC facilities, and how school-based PHC services will be re-introduced. Greater levels of civil society engagement will also be required if the new system is to be designed effectively and maintain accountability.

11 NHI pilot districts

In April 2012, piloting of NHI commenced in eleven pilot districts in all nine provinces of South Africa. This initial phase allows the DoH to evaluate the proposed administrative and service delivery reforms necessary to implement an NHI. It also allows for the identification of barriers to efficient healthcare planning and, hopefully, ways to overcome them. Budgeting and management lessons will be evaluated.

But our initial assessment of the pilot phase found little evidence of a coordinated implementation strategy. Most of the district administrators, facility managers and healthcare workers were unclear about what the NHI piloting phase hoped to achieve or what they were expected to do.

At the end of July, the National Department of Health presented its first 12-month progress report of the NHI sites. The findings of the report were based on questionnaires, pilot district reports, and site visits with the District Health Management Teams. While the tone of the report was generally positive, it is evident that there are at least four key weaknesses in the pilot phase.

Budgets spent late

The first of these is the failure of the DoH to provide adequate budget guidance. By the end of the 2012/13 financial year, only 77% of the budget allocated to the pilot districts through conditional grants had been spent. Most problematically, 90% of the available funds were used only in the fourth quarter of the financial year. This, as the report admitted, was because the DoH failed to provide clear guidance about which NHI initiatives the funds could be used for. The surge in spending occurred only after the DoH revised its grant criteria.*

At the district level, we need to ensure that there are enough doctors, nurses, specialists, and community health workers to deliver promotional, preventative, curative and rehabilitative services.

* Annual district health expenditure reviews were completed. However, the annual report did not include the outcomes of the reviews or indicate if or when they would be made available to the public.



The tiny Pilani Clinic in the OR Tambo District has no electricity and only one professional nurse serving 150, 000 people. Photo by Thys Dullaart

Budgeting problems are likely to persist. The 2013/14 NHI Pilot District plans have yet to be made available, despite the fact that more than a third of the financial year has already passed. Once again, communities will be unable to monitor the district sites because they do not have the necessary information about what is being implemented in the current financial year and at what cost.

The absence of clear guidance reflects a significant failure on the part of the DoH to comply with the regulations and laws governing public planning and budgeting. This has also negatively impacted both our ability to evaluate the costs of establishing a properly functioning NHI system, and our ability to capture useful managerial insights.

Infrastructural improvements are falling behind

A second significant challenge has been the lack of adequate improvement to the infrastructure in the pilot districts. The report explained that, in some instances, progress was slow because of poor coordination between the National Department of Health and the Department of Public Works. Preparations for the new NHI services and innovations necessarily depend on improvements to the standard of the available facilities and the coordination of functions between the DoH and the Department of Public Works.

As part of its review of the piloting process, the DoH compared the standards of the NHI pilot facilities in 2012/13 with the baseline assessment. In the new assessment, mean scores across most domains had declined, including cleanliness (-6%), the availability of medicines and supplies (-8.7%), staff attitudes (-3.6%) and patient safety (-5.8%). The provision of a comprehensive package of primary healthcare services is the foundation of South Africa's new NHI scheme. Only a third of NHI pilot site facilities had the necessary staffing levels, infrastructure, pharmacy services, and equipment to support these.

It remains unclear if the size of the budget allocated during the NHI pilot phase is sufficiently large to support the planned service scale-up. The failure of the DoH to discuss this issue in their report was a conspicuous omission.

Uneven progress

A third key problem in the pilot phase of the NHI scheme has been the uneven progress across the districts. The Eden District (Western Cape), Pixley ka Seme District (Northern Cape), Tshwane District (Gauteng) and uMgungundlovu District (KwaZulu-Natal) all significantly outperformed the OR Tambo District (Eastern Cape) and Vhembe District (Limpopo Province). For example, only 2% of primary healthcare facilities in the OR Tambo District and 15% in the Vhembe District were able to provide the full package of primary healthcare services. In

contrast, more than 80% of the facilities in the Eden District, 76% of the facilities in the uMgungundlovu District, and 65% of the facilities in the Pixley ka Seme District had sufficient capacity.

This unevenness is mirrored in the larger human resource capacity disparities across the districts. Approximately 90% of all posts for doctors at hospitals in the districts of Eden and uMgungundlovu are filled, compared to 60% in the OR Tambo District, and 29% in the Vhembe District. Similar differences were noted with regard to the nursing posts at hospitals: while 92% of the nursing posts are filled in the Eden District and 97% in the uMgungundlovu District, only 51% and 36% of the nursing posts are filled in the OR Tambo and Gert Sibande Districts respectively.

These disparities extend to the primary care level: 95% of the nursing posts are filled in the districts of Eden and uMgungundlovu, while only 37% and 30% of the nursing posts are filled in the OR Tambo and Vhembe Districts respectively. Even these statistics may not reflect the severity of the organisational problems on the ground: the organisational charts are so out-of-date and so poorly managed, that they do not reflect the current staffing hierarchy at these facilities. They are therefore unlikely to provide any indication of how close the facilities are to meeting the basic requirements of the new NHI scheme.

The fact that the DoH has clearly failed to prioritise or adequately fund outreach services during the pilot phase of the NHI scheme is of particular concern. Based on the DoH's own assessment, it is clear that little progress has been made to ensure that community health care workers, rehabilitation professionals and nurses have the necessary transport, equipment and support for undertaking home-based care. If primary healthcare is the foundation of the NHI, as the DoH claims, then the resourcing of an effective outreach and referral system should be at the forefront of the piloting process.

Clinic committees and hospital boards

The fourth key weakness evident in the report is the lack of progress in establishing clinic committees and hospital boards. These structures are meant to serve as the principal institutions of community participation in primary healthcare service delivery. While all the districts were reported to have hospital boards and clinic committees, closer scrutiny of the report revealed little detail about how these bodies

function and the extent to which they facilitated meaningful community participation.

The available information suggests that there are already unacceptable variations in the quality of the structures which are intended to facilitate public participation. In the Pixley ka Seme District in the Northern Cape for example, four out of thirty-six clinic committees are described as "functioning optimally" in the report. In contrast, in the OR Tambo District, all the hospitals have boards "but functionality is an issue". The Gert Sibande District has no protocol for the establishment of clinic committees, and has used the provincial protocol for Hospital Boards instead.

Meaningful public participation in the health system is critical. An environment which empowers community members to exert influence and oversight over healthcare can help communities to ensure that health services are tailored to their specific health needs.

The weaknesses and failures noted during the piloting phase can be explained, in part, by the historical neglect of many of the districts. But the purpose of the NHI pilot districts is to determine how reforms under the NHI could be implemented, particularly in deprived and neglected districts in South Africa.

Piloting therefore needs to prioritise reforms and interventions that promote greater equity, efficiency, effectiveness and participation. Thus far, the NHI piloting scheme has largely failed to do so.

Without a coordinated piloting effort which encompasses all levels of the healthcare delivery system we can only ever expect uneven implementation. The involvement of the national, provincial and district level administrations in the pilot scheme requires carefully developed plans. Such plans need to be based on the resource needs of the districts rather than the ability of local interests to negotiate beneficial deals. Future NHI plans must reflect a proper assessment of district requirements with reference to the NSP. Putting such plans in place will help us realise the core objective of the NHI scheme: ensuring that all South Africans are able to lead a long and healthy life.

Future NHI plans must reflect a proper assessment of district requirements. Putting such plans in place will help us realise the core objective of the NHI: ensuring that all South Africans are able to lead a long and healthy life.

Daygan Eagar works at the Rural Health Advocacy Project (RHAP) and is the manager of the Rural Proofing Programme; Thokozile Madonko is the coordinator of the Budget Expenditure and Monitoring Forum (BEMF).



Women wait for hours to be seen by a primary health care nurse on an Eastern Cape health outpost in the OR Tambo district. Photo by Thys Dullaart

Nonyameko's story

Nonyameko Ntiyo (38) was without antiretrovirals for three months because of stock-outs at the village clinic in Lusikisiki in the Eastern Cape. Ntiyo, who is taking ARVs and anti-TB medication, said that the doctors had changed her treatment regimen. She was supposed to receive AZT, Aluvia and 3TC. However, no Aluvia was available from February to April 2012. During this time Ntiyo fell ill and spent almost two weeks in hospital.

"Every time I went to the clinic I would be turned away without any pills. Aluvia (lopinavir/ritonavir) was always not available. It cost me R17 to get to the clinic by taxi and when I didn't have [the] taxi fare I walked for about an hour to reach the clinic. I would sometimes ask my dad to fetch my pills for me when I became too weak to go by myself," Ntiyo recalls.

She says her health deteriorated rapidly and matters only improved when her friends and neighbours reported the stock-outs to the TAC office.

"That is when things started to change," she says.

"The clinic gave us two weeks' supply and we had to come back for more when they were finished, which meant I had to go to the clinic twice in one month. Sometimes the nurses would also try to assist by sending one of their staff members to the Gateway Clinic, but they would do that only after we became aggressive and firm with them. Otherwise they just told us to go ourselves in search of ARVs," says Ntiyo.

She says some patients gave up trying to access their medication.

Ntiyo says the pharmacist did not explain to them that alternatives were available and was sarcastic to her. The pharmacist said he was not in the business of manufacturing pills, only receiving and distributing drugs.

"We must thank TAC for educating us that we can stand up for our rights," she said.

Tholakele's story

The clinic that Tholakele Mhleshe (64) relies on frequently runs out of antiretrovirals (ARVs). The lack of consistent treatment may have contributed to her contracting tuberculosis and losing weight, along with a plummeting CD4 cell count. Mhleshe tested positive for HIV in 2007 and started taking ARVs four years later at the SAPPI Clinic, near her home in Mthethwa, KwaZulu-Natal.

According to Mhleshe the stock-outs started last year and have become more frequent. "That was when I started getting sick and contracted TB, lost a lot of weight and became very weak with my CD4 count dropping significantly," she recalls.

Mhleshe said patients at the clinic would often share experiences about how the lack of treatment was affecting their health.

"We would be told to go to Ethembeni Clinic by the nurses and a return trip would cost me R50. This is too much for me. I had to try not to add it all up because I knew this concerned my life".

WHY ARE THERE NO MEDICINES AT THE CLINIC?

By Marcus Low and Mary-Jane Matsolo

When patients go to clinics or hospitals many are told that the medicines they need are unavailable. Why does this happen and what can be done about it?

The Treatment Action Campaign (TAC) regularly responds to complaints about stock-outs of essential medicines at health facilities. On some occasions, patients have suffered because they have been unable to obtain antiretroviral (ARV) drugs. At other times, clinics have run short of TB medicines and basic pain medications.

When TAC helps with complaints like these, we first try to communicate directly with the staff at the facilities and depots involved to find out why medicines have not been delivered. At other times we have had to ask the Department of Health to provide emergency stocks of ARVs when provincial structures have failed to do so. What these cases reflect consistently is the deplorable state of our provincial health systems, the lack of management skills at all levels, and a lack of political will to address weaknesses directly.

FROM THE FACTORY TO THE PATIENT

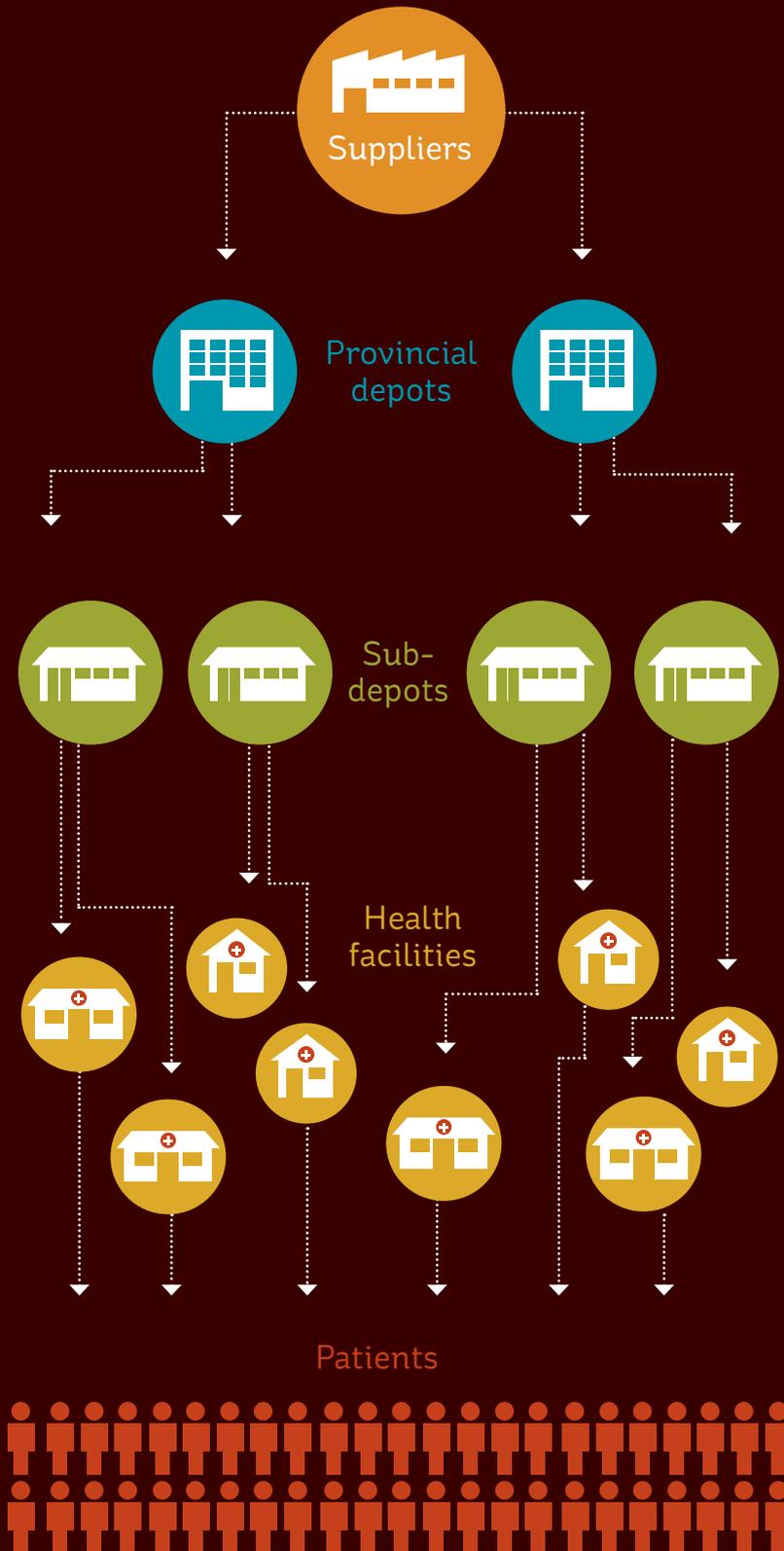
The distribution supply chain for drugs is long and complicated. Things can go wrong at various points along the way.

The distribution chain described above has many links. At each point in the chain, good management is required to ensure that the medicines flow as they should. Many of the recent stock-outs in South Africa are likely to have been caused by poor management at various points along this complex chain.

The monitoring of what happens along the distribution chain in South Africa is insufficient. While the Department of Health is able to track stock levels at depots, it is unable to track stock levels at the facility level. This makes it difficult to track where and why the system is failing. It also increases the risk of medicine thefts at the clinic level.

FROM FACTORY TO PATIENT

The distribution supply chain



Suppliers (medicine manufacturers and importers). The state buys ARVs from pharmaceutical companies according to the conditions of a special two-yearly ARV tender. If pharmaceutical companies fail to deliver the required quantities on time this can lead to medicine stock-outs at health facilities. It is essential that the state orders the right quantities of medicines from suppliers. Accurate forecasting of future needs is needed.

Depots receive medicines from suppliers. The drugs are then distributed to sub-depots and, in some cases, directly to health facilities. Good stock management and prompt responses to orders from sub-depots and health facilities are essential if problems are to be prevented down the line.

Sub-depots are the 'middle-man' between the depots and the health facilities. Medicine stock-outs occur if, for example, sub-depots are slow to respond to orders placed by health facilities. Similarly, if the sub-depots don't place their orders on time with the provincial depots, there may be shortages. Some sub-depots struggle because they don't have enough space to store medicines.

Health facilities (clinics and hospitals) place their medicine orders with the depots. If the orders are late or incorrect, stock-outs of essential medicines may happen. In a well-functioning clinic, good planning, good stock management, and correct and timely ordering are essential.

Patients who do not get HIV treatment when they need it can develop drug resistance and get sick. Medicine stock-outs may also lead to patients being given smaller amounts of medicine. This means they have to visit the clinic more regularly. Patients will then have to spend more money on transport and this will impact particularly on the poor.

NO MEDICINES AT THE CLINIC

HOW DO WE SOLVE THE PROBLEM?

Improving the quality of medicine distribution cannot be achieved immediately. In the long-term, the Department of Health must ensure that more qualified and capable people are put in charge of medicine distribution, management and budgeting. In the shorter-term a number of structural changes and technological solutions could be implemented:

- More direct distribution: the distribution process can be simplified by omitting some of the existing steps described above. The Department of Health has launched pilot projects to test whether it is more efficient, for instance, to distribute medicines directly from drug suppliers to health facilities. Direct distribution from depots to health facilities (thus skipping the sub-depot link) may also deliver improved results.
- Using private sector pharmacies: another option being considered by the Department of Health is allowing public sector patients to collect their medicines from private sector pharmacies. The Department of Health is holding discussions with various private sector pharmacies and a pilot project is expected to begin in early 2014.

- Electronic records at facilities: the Department of Health's computer systems only provide information about stock levels at depots. Information about stock levels at the facility level is not collected. If stock levels at facilities are stored electronically, shortages or potential shortages could be identified faster and stock levels managed better.
- Split tenders: to reduce the risk of supply shortfalls, the Department of Health has split some tenders between companies. The new fixed-dose combination of antiretrovirals, for example, which is provided as a first-line treatment in the public sector is purchased from three different companies (Aspen, Mylan and Cipla). If one company is unable to supply the drugs on time, it should be possible to rely on the others in the short-term.

Eight causes of medicine stock-outs

1. Lack of **human resource** capacity
2. Lack of an **early-warning system**
3. **Suppliers failing** to meet tender quotas
4. Premature exhaustion of **budgets** and/or provinces failing to pay suppliers
5. Faulty **processing** at depots
6. Faulty **ordering** practices at facilities
7. **Lack of transport** between depots and facilities
8. **Corruption**

Marcus Low is joint editor of NSP Review and editor of Equal Treatment magazine. Mary-Jane Matsolo is a junior communications officer at the Treatment Action Campaign.

THE STOP STOCK-OUTS PROJECT

The frequency of widespread stock-outs of essential medicines has led a number of civil society organisations to explore alternative solutions to improving the reliability of drug supplies. TAC, the Rural Health Advocacy Project, the Southern African HIV Clinicians Society, the Rural Doctors Association of South Africa, SECTION27, and Médecins Sans Frontières (MSF) have formed the Stop Stock-outs Project (SSP).

The aim of this project is to provide patients, nurses and doctors with an easy way to report stock-outs either over the phone or via the internet. Reports will be fed into a central database and responded to as needed. All data will be anonymised and shared openly with the Department of Health and other parties. (Further details can be found at www.stockouts.co.za)

Right: TAC members and partner organisations participated in a National Day of Action on 12 September to protest against stock-outs of essential medicines at clinics and hospitals. Photo by Suhair Solomon



MEN WHO HAVE SEX WITH MEN:

A NEGLECTED HIGH-RISK GROUP IN SOUTH AFRICAN HIV POLICY AND SERVICE DELIVERY

By Eduard Grebe

Men who have sex with men are at high risk of HIV infection but less likely to use mainstream healthcare. So why has this population group been neglected in HIV research, and how can we design better-targeted services and support?

Heterosexual transmission of HIV accounts for the majority of new infections in South Africa. But has HIV transmission among men who have sex with men (MSM) been neglected in our national response to the epidemic?

Our country has made major advances in overcoming official discrimination. The Constitution explicitly bans discrimination on the grounds of sexual orientation, sodomy is no longer a criminal offence and, in 2006, South Africa became the first African country to recognise same-sex partnerships. Residence rights have also been given to same-sex foreign partners.

But in many settings, same-sex sexual encounters remain stigmatised and still occur in secret. Many are between men who do not regard themselves as gay. Some involve men who don't only have sex with men. But same-sex HIV transmission in South Africa is still not a research or policy priority. As a result, major knowledge gaps exist in our understanding of the epidemic and there are too few targeted prevention efforts for MSM. This means that although we have legally secured gender equality, it is still difficult for MSM to access prevention and healthcare support.

Key populations in the NSP

With the number of new HIV cases declining and the success of efforts to scale-up treatment increasing, there is now a new focus on neglected high-risk populations. The 2011 National Strategic Plan on HIV, STIs and TB, for example, identifies a range of key high-risk populations, including MSM.

Sex workers, truckers and young women are among the subgroups increasingly recognised by policymakers as being in need of targeted interventions. Statements made by SANAC and by the Department of Health's HIV Prevention Director, Dr Thato

Chidarikire, reflect this new attention. But efforts focused on MSM are often a policy afterthought rather than a major priority.

Support services provided by the Health4Men clinics in Cape Town and Johannesburg are aimed at men more broadly and MSM specifically. Similarly, the Esselen Street Clinic in Hillbrow targets its services at sex workers. The uptake of these services has been significant. This shows the benefits of providing health services that are tailored to the needs of marginalised groups and delivered by compassionate healthcare workers.

These programmes remain largely outside the mainstream health system, but they hold important lessons about how healthcare can be made more relevant and how to better reach marginalised key populations. Helping people who are at risk requires adapting mainstream healthcare. This requires the deployment of specialist services in settings in which these key populations are found. It is particularly important that such services are free of prejudice.

A lack of knowledge

Efforts to target MSM continue to be impeded by a lack of basic scientific knowledge. The epidemiology of HIV transmission in this marginalised population remains poorly understood. Estimates of HIV prevalence among MSM, for example, vary between 10% and 33%.

Studies of HIV risk in the MSM population are often qualitative or based on non-random samples. These studies give us rich data about issues such as the social and sexual experiences of MSM and have helped us to identify factors driving individual risk taking. But sampling bias within some of these studies has meant that their scientific value is limited. Only large, randomly sampled population-based studies can provide us with accurate and comprehensive findings on the epidemiology of transmission in this group. In addition, few of the studies done so far include questions about sexual behaviour or about the sexual practices of MSM.

The HSRC's National HIV Household Survey is one of the few surveys that has provided us with estimates of HIV incidence and prevalence in South Africa. Although the latest survey has not yet been published (only a summary was released at the South

African AIDS Conference last year), the previous report contained no references to MSM. The report also made no recommendations about other key vulnerable population groups. This needs to change: better surveillance of epidemiological trends is needed. Measuring the sexual behaviour of the entire population – including vulnerable groups such as MSM – will lead to better HIV and STI prevention policies. This will also help us understand if the rate of HIV infection among MSM is higher than in the general population.

Targets in the NSP

One of the strategic objectives of the NSP is to make accessible “a package of sexual and reproductive health services to prevent HIV and STIs, with an emphasis on key populations”. However, the NSP lacks clear strategies to address conservative attitudes among healthcare workers. Discrimination and prejudice within the health services deter many MSM from accessing care. But the NSP also does not make it clear how mainstream health services can become better at serving the needs of MSM. Specialist initiatives such as Health4Men and the Esselen Street Clinic are valuable but do not reach the majority of those at high risk.

To design better interventions and to improve targeting, we need to expand and improve our research on high-risk populations in South Africa. We also need to better understand the social and behavioural risk factors in these groups.

Targeted interventions need to be expanded and integrated into the mainstream health system. The NSP, and the encouraging statements made by senior health officials, are important steps forward, but substantial and rapid action is needed.

Eduard Grebe is a post-doctoral fellow at the Centre for Social Science Research at the University of Cape Town.

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Photo by Bonginkosi Mthembu-Moloi

THE PUBLIC SECTOR IS FAILING MEN WHO HAVE SEX WITH MEN

By Luckyboy Nkhondwane

South Africa is one of the world's most liberal countries with regard to issues of sexual orientation. But there are major gaps in the public health sector services, especially for men who have sex with men (MSM). Many find it difficult to access health services tailored to their needs.

I haven't used the public health system in more than 10 years because of the challenges I experience when I have to explain my sexual preference and needs to healthcare workers. My unhappiness stems from the fact that when you do receive help, it is usually unfriendly, prejudiced, or even substandard.

The healthcare providers themselves are not really to blame for this situation. It is the health system itself that is flawed. I believe this challenge is not one that's only faced by MSM, but by South African men in general. The health system is not geared to tackle individual needs. It's a challenge that seems even bigger when you have sexual preferences that are different to what some regard as 'normal'.

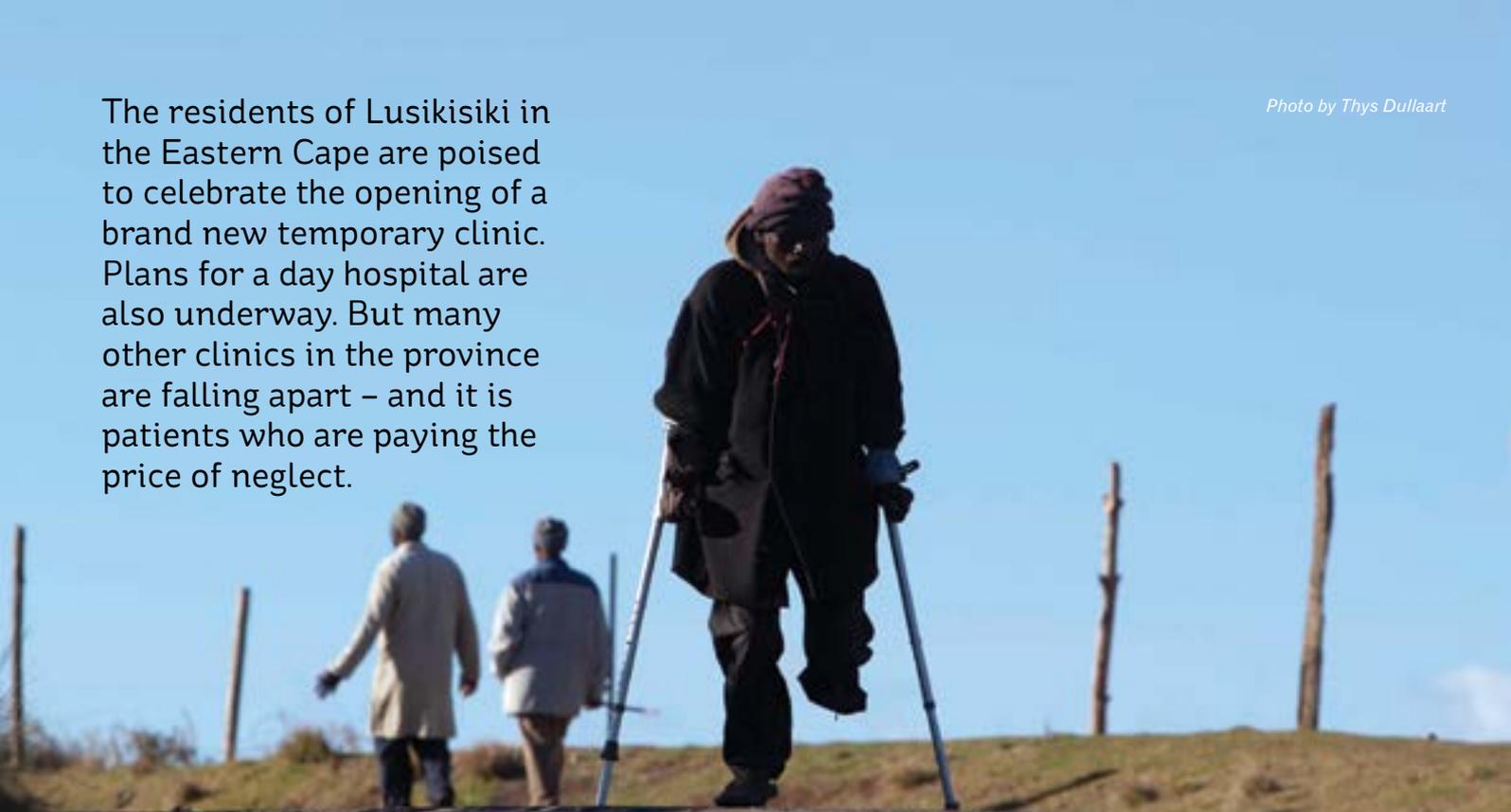
MSM of all ages would rather go to private doctors if they can afford to. Others simply choose to stay away completely instead of having to face prejudice.

Our health facilities don't provide education for men like me about HIV prevention and treatment, or about other sexually transmitted infections. They also fail to provide the critical things I need, such as lubricants and extra strength condoms which are recommended for anal sex.

Only the interventions of agencies like Health4Men, OUT, and the Desmond Tutu Foundation have given MSM the chance to access proper healthcare. Sadly, these agencies do not operate nationally, and this leaves most people in the MSM community with no choice but to go to local health facilities.

Our health system should be able to deal with all cases, especially when patients belong to vulnerable or high-risk groups.

The residents of Lusikisiki in the Eastern Cape are poised to celebrate the opening of a brand new temporary clinic. Plans for a day hospital are also underway. But many other clinics in the province are falling apart – and it is patients who are paying the price of neglect.



COMMUNITY ACTIVISM: A TALE OF THREE EASTERN CAPE CLINICS

THE LUSIKISIKI CLINIC

The village clinic in Lusikisiki is an example of how civil society activism can help to bring about progress and change. Residents protested because their clinic facilities consisted of just two tents and a rickety park home. Even the pit toilets were unfit for human use.

Attempts to engage the provincial MEC of Health, Sicelo Gqobana, had failed. So the Treatment Action Campaign (TAC) asked SECTION27 for help with exploring litigation options. Papers requesting a response from the MEC and the National Minister of Health were filed by TAC with SECTION27's support.

After Dr Aaron Motsoaledi, the Minister of Health, had been briefed by SECTION27, an official team was dispatched to Lusikisiki. Within days, a temporary structure had been erected and plans for a day hospital were presented. A new, temporary clinic will be opening soon.

The residents of Lusikisiki are looking forward to having decent health facilities. But many other Eastern Cape villages still have to make do with substandard health facilities.

THE PILANI CLINIC

To reach the Pilani Clinic from Mthatha, a town in the Nyandeni area, requires a two-hour drive along potholed roads. The clinic, in the OR Tambo District Municipality, is one of South Africa's pilot sites for a new National Health Insurance scheme.

But the clinic has no electricity and an unreliable water supply. Three rondavels serve as consulting rooms, and the waiting areas inside are too small. The gas supply for the fridge in which the clinic's drugs are kept is erratic. Pit latrines near the clinic block frequently.

Only one professional nurse works at the clinic which serves an area in which 150,000 people live. Prior to 2006, when the nurse agreed to work there, the clinic had been closed for years.

Patients are often sent home when the nurse and her assistant don't reach the end of the waiting lists. Drug and vaccine stock-outs are frequent.

THE HAMBURG CLINIC

Hamburg Clinic, located between Port Alfred and East London, is in the Amathole District and operates in a building which has partially collapsed. Despite the fact that the building is unsafe for patients and staff, it continues to be used.

Staff have reported their concerns about the condition of the building to the district health authorities. A site visit, however, led the health authorities to conclude that only minor renovations were needed. Further deterioration has occurred since the delegation visited. "The clinic is ... in danger of collapsing," says a staff member.



Pilani Clinic has a critical shortage of space. This means that babies are weighed in the open air. Photo by Thys Dullaart

Anso Thom is joint editor of the NSP Review and a former journalist at Health-e News.

OUT OF SIGHT, OUT OF MIND

Many remote clinics are in bad condition. As one activist commented, it is a case of the facilities being "out of sight, out of mind". Had it not been for the work of the people in Lusikisiki, the clinic may have remained forgotten. We need further committed activism to ensure that the progress made in Lusikisiki is repeated in towns such as Hamburg and Pilani, and across the Eastern Cape.

Activism alone is not enough however. The Eastern Cape Department of Health needs to maintain and improve clinics without being prompted by activists who draw attention to these failings. The Department needs to develop a comprehensive understanding of what health facilities are available, what state they are in, and what the healthcare needs are in the communities it serves. Without this, the provincial Department of Health will not be able to deliver services effectively.

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Photo Credit: Bithin Das



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