in the state of health in South Africa
TREATMENT
ACTION
CAMPAIGN
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EDITORIAL INDEPENDENCE
The opinions expressed in Spotlight do not always reflect the views of TAC or SECTION27.

The Treatment Action Campaign (TAC) advocates for increased access to treatment, care and support services for people living with HIV, and campaigns to reduce new HIV infections. Learn more about the TAC’s work at www.tac.org.za.

SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights, particularly the right to health. Learn more about SECTION27’s work at www.section27.org.za.

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Pledge for Prudence

Mark Heywood

One of the early TAC leaders and founders Prudence Mabele died in July. Her death came as a shock, but even in death Prudence has catalyzed discussions on resistance, treatment fatigue and other challenges. Spotlight pays tribute to this giant of the struggle via a heartfelt and powerful obituary delivered by Mark Heywood at her memorial in Johannesburg last month.

My dear friend and comrade Prudence

Thank you for honouring me as a ‘friend’ to speak at your funeral. You have many beautiful friends and comrades, so I am not sure why I am the one to speak. That is why, first, I must pay tribute to your better friends and comrades, and thank them for the support and love they have shown you during and after life. Prudence, you were an activist – a warrior woman – a woman in a line of activists; many of whom have passed, some of whom are still larger than life. I think of Charlene Wilson, Sarah Hlahlele, Vuyiseka Dubula, Sipho Mthathi, Vuyo Gonyela, Anso Thom, Bev Ditsie, Phindi Malaza, and Sharon Ekambaram, to name a few in a long line.

Indeed, the best leaders that I know in the response to oppression and violence – of which HIV is just a part – are the women who have risen to fight in solidarity with other women; honest women, incorruptible, self-sacrificing, principled.

Prudence, at your funeral I have to decide whether to speak like you – always principled, brave, bold, sometimes rude – or like me: more shy, careful, cautious, scared about speaking truths to power. You seemed never to be scared.

I will try to be something in between.

Your death on Monday 10 July left me numb. It left me feeling neglectful; wanting. I had suddenly lost someone I loved (I realise now that I did love you), but whose life and presence I took for granted. Sometimes we activists are so ‘busy’ that we pass each other like ships in the night. But ‘busy’ with what, if we don’t leave time for our friendships?

I feel I did take you for granted – you had been a part of my life since the middle of the 1990s. We in and out of conferences together, marched together, mourned together, mobilised together. I remember you in the earliest days of the Positive Women’s Network, of the AIDS Consortium, of TAC.

This week I found a picture of you with Vavi, Zuckie Achmat and me, celebrating the victory of TAC over the Pharmaceutical Manufacturers’ Association in 2001. If we could excavate my memory, I’m sure we would find pictures of you when we won over PMTCT; when we protested at the International AIDS Conference in Toronto; when we re-established the SA National AIDS Council. Recently, I saw a picture of you marching to demand the resignation of Jacob Zuma.

A book should be written about your life. We need to tell your story – not just for those who know it, but for those who don’t; because it is a story of courage and hope. It is the story of a heroine.

One truth about you, Prudence, is that you were not a hypocrite. At the time of your death, I hear people lament that civil society is divided. People tell us we must ‘overcome our divisions’, but you never had any truck with that. You said, “While I was at home sick with PCP and vertigo... I was removed like Thabo Mbeki – at SCF (SA AIDS Council) a motion was passed and my removal happened; mostly friends nominated each other, and without a quorum.” You told me that “there’s a lot you do not know that makes me disagree with my chair, and because of that I am now victimised.”

The people who undermined you now preach unity. But unity means we must be silent about their transgressions. We will build unity. Yet we will! But it will not be a fake unity. It will be unity with the poor, the marginalised, the violated and discriminated against. Unity with sex workers. Unity with the vulnerable. What we won’t do is build unity with thieves and murderers.

Remember, one of the oldest slogans of the AIDS movement was ‘Silence = Death’. Today, once again, there is far too much silence. Once again there is too much death. We have to stop the silence. We have to stop the death. Prudence, I want to finish my tribute by making a pledge to you. I ask those reading this to repeat my words to themselves. 

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For you, Prudence, we will:
+ Ensure that all young women have access to PrEP and other ways of protecting themselves, in the same way that we fought for Nevirapine for pregnant women with HIV.
+ Campaign for the resources and political will to stop violence and murder against women and the LGBTQI+ community.
+ Ensure the decriminalisation of women, men and transgender folk who engage in sex work.

For you, Prudence, we will:
+ Never steal
+ Never manipulate
+ Never deceive or lie
+ Never take advantage of AIDS, TB or any other cause of ill health, for our own benefit.

For you, Prudence, we will:
+ Recognise the intersectionality of AIDS with ensuring quality education, employment, and stopping corruption. Fighting AIDS means fighting for human rights and social justice.
+ Call on our country’s leaders to wake up again to HIV and TB. It’s not over. It’s not half over.
+ Call on Deputy President Ramaphosa and the honest members of the ANC to remove President Zuma from power, because we cannot have a good response to AIDS in a corrupt government.

Prudence, we will remember you for as long as we live. Your life was not in vain.
2. From an HIV struggle to a healthcare system struggle

For most of TAC’s history, the focus has been on HIV and related opportunistic infections. TAC’s biggest struggle so far, after all, was the struggle for ARVs. The T-shirts that made TAC famous say ‘HIV positive’ on the front. Most importantly, TAC is a membership-based organisation, and most of our members are living with HIV – so HIV will always be a critical part of our work. Yet though we have won the battle for HIV treatment, the healthcare system is falling apart. And the healthcare system is falling apart not only for people living with HIV, but also for people with tuberculosis, diabetes or cancer.

Thus when TAC campaigns for quality healthcare for all, the organisation is not just campaigning for people with HIV, but also for all brothers and sisters with other diseases. We all stand in the same long queues. We are all harmed by medicine stockouts. In this new phase in TAC’s history, TAC has the opportunity to be a home for all poor people who need healthcare, not just people living with HIV.

3. From the national to the provincial and the local

TAC has always done its work on all levels, from local to national. The heart and life-blood of TAC has always been its branches. The national victories we have won were only possible because of the power of TAC’s branches. Now more than ever, it is important that TAC’s branches remain strong, and that TAC’s work is driven by its members and its branches. One of the important recent initiatives is that all TAC branches were mandated to adopt a clinic. In this way, TAC will increase accountability on the front lines, where people interact with the healthcare system.

More broadly speaking, however, there has been a shift in focus in the last five years from national to provincial, as TAC’s struggle has moved from a policy struggle to an implementation struggle. In South Africa, the National Department of Health decides on policies, but the provinces are responsible for implementation. Thus when TAC sees the policies are good, but the clinics are still in crisis, it is the provinces TAC must hold accountable. In recent years, for example, pressure from TAC has helped to unseat underperforming MECs for Health such as Benny Makalakane in the Free State and Sicelo Gqobana in the Eastern Cape. It is critical that this kind of provincial-level work continues.

Looking ahead

The 2017 National Congress will set the direction for TAC over the next five years. Much of TAC’s success in the years to come will depend on the quality of the national leadership elected at the Congress. More than ever before, TAC needs brave and dedicated leaders who can think and act strategically in the interests of TAC’s members. The good news is that in someone like Anele Yawa, TAC already has a very strong leader. However, it remains an open question whether Yawa will be re-elected, and who the rest of the leadership team would be. One would also expect at least half of the national leadership positions to be taken up by women.

In addition to the leadership question, there are at least two critical issues that the Congress must resolve. Firstly, TAC must decide to what extent it wishes to remain an HIV organisation, or whether it will become an organisation for all poor people who are dependent on the public healthcare system. To some extent, this shift has already taken place in TAC’s work; but hopefully the Congress will make the shift explicit, and make it clear that TAC is open to all – irrespective of HIV status.

The second issue, and one that is probably even more important, is what decisions the Congress will make regarding the current political crisis in South Africa. While it is tempting to keep TAC’s focus on health care only, the reality is that corruption and state capture are impacting the healthcare system. For example, the economic crisis has meant that health budgets have been unable to grow as one would hope – which has contributed to posts in the public healthcare system being frozen and left vacant. While provinces lack the money to employ more healthcare workers, the country is losing billions of Rands to corruption.

Though TAC has taken a stance against corruption and state capture in a few media statements (TAC has endorsed the Save SA movement, for example), these statements do not carry the same weight as a firm and clear Congress resolution. A critical question for the 2017 TAC National Congress is thus whether the organisation will take a clear resolution against state capture and call for the removal of President Jacob Zuma – given that he is at the centre of most state-capture allegations. If TAC sidesteps or fails to be firm and clear on this issue, its political relevance will be much diminished. TAC’s attempts to fight corruption at provincial level will simply ring hollow if TAC can’t take a strong resolution on state capture and corruption at the highest level.

TAC leaders 1998–2017

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<tr>
<th>YEAR</th>
<th>GENERAL SECRETARY</th>
<th>CHAIRPERSON</th>
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<tbody>
<tr>
<td>1998 - 2003</td>
<td>Mark Heywood</td>
<td>Zackie Achmat</td>
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<tr>
<td>2003 - 2005</td>
<td>Sipokazi Mthathi</td>
<td>Zackie Achmat</td>
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<tr>
<td>2005 - 2007</td>
<td>Vuyisela Dube</td>
<td>Zackie Achmat/Nonkosi Khumalo</td>
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<td>2007 - 2010</td>
<td>Vuyisela Dube</td>
<td>Nonkosi Khumalo</td>
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<td>2010 - 2013</td>
<td>Vuyisela Dube</td>
<td>Nonkosi Khumalo/Anele Yawa</td>
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<td>2013 - 2017</td>
<td>Anele Yawa</td>
<td>Nhlenzani Mavuso</td>
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Dating when HIV-positive can be very tricky. When do you disclose your status to a new sex partner? How do antiretrovirals impact on your sex life? Why do we sometimes take risks that don’t seem rational? Relationships are hard, but can be so much harder when you have a background condition that is sexually transmitted. The show went well, but I found some of the callers talking about their experience of disclosure surprisingly moving and upsetting. People were calling in, talking about the enormous impact of HIV on their sex lives, and of partners slowly pushing them away due to their status. This was not the violent, ignorant stigma that we easily identify and loudly denounce, but a more subtle, much more personal rejection. It reminded me of a good friend who is HIV-positive, who when she is about to engage in sex with a guy, says he often behaves as if he were doing her a huge favour, despite her being completely non-infectious on treatment. These little and not-so-little indignities can be devastating, and can prick holes in your self-esteem. Getting reliable support after disclosure is far from guaranteed.

A few weeks ago we lost Prudence Mbele, a beloved long-time activist living openly with HIV, who died of TB. Prudence was famous for her ‘pill holidays’ – a big no-no in HIV-land, as it leads to further immune damage. The idea of someone stopping their life-saving tablets – even temporarily – boggles the minds of most health providers. Her death triggered an intense media and Facebook/Twitter reaction, filled both with criticism at her choices as well as empathy, as people shared their own hard stories about taking antiretrovirals. Yet this notion of ‘pill fatigue’ affects lots of people in the HIV field and beyond, and generates a lot of chatter on social media.

Pill fatigue is a difficult concept to swallow, as a health professional. The daily tablet we use for HIV is small and getting smaller, has very few side effects, and is becoming safer all the time. Public health guidelines in South Africa recommend that a huge proportion of our population need tablets for diabetes, hypertension and cholesterol, among other ailments, especially as people get older. Pills are a part of normal life for everyone as they get older – so why should HIV-positive people complain of pill fatigue? Some of those reasons relate to anxiety and depression and stigma, now strongly linked to delayed presentation for treatment, as well as adherence to their meds. Sadly, mental health issues are more associated with medical hot air than with any content; very few
resources are allocated specifically to this area in either the public or the private sector, despite tons of data suggesting they are important. We have very little spiritual and smart mental health professionals trying to change this, but there is an inertia in the current health system. It is also coupled with harsh societal views around mental health – depressed people are told to pull themselves together, think positive thoughts, be grateful – which are less than helpful to people experiencing sometimes devastating physical symptoms as a result of mental illness. The truth is that mental illness is probably just as stigmatised as HIV.

What does all of this mean, for someone with HIV? There is probably just as stigmatised as HIV. It is rejected or judgemental about having the disease. There needs to be more community awareness of mental health, just as it is not a moral failing to suffer mental illness, just as it is not a moral failing to be HIV-positive, or have any sexually transmitted infection. At South Africans, there are many things that grind us down: corrupt political leadership, lack of support for people with HIV, or have any sexually transmitted infection. It is no wonder that mental illness is so prevalent in our society. Sadly, we have been slow to acknowledge this and implement adequate policies to help mitigate mental illness.

Just as with HIV, every single one of us knows another person who is experiencing mental illness. However, this may be hidden – due to stigma, shame, lack of understanding, and lack of adequate treatment. As a country, we achieved a lot when we started taking HIV seriously; through activism, scientific research, transformed health delivery – and a lot of hard work at all levels, we managed to turn the epidemic around and make HIV a manageable condition. We can do the same with mental health, if we are motivated to do so.

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### Identify your mental health symptoms

It’s a good idea to pay attention to your mental health, as well as your physical health. The first step is noticing whether you are feeling different – do you have feelings of anxiety or depression? Are you feeling sad, a lack of energy to get through your routine, or disrupted sleep or eating patterns? If so, and if these persist for a couple of weeks, you may be becoming depressed.

Do you have persistent and repetitive thoughts, worrying about your life or other problems? Do you notice physical symptoms such as shortness of breath, churning stomach or nausea, dizziness or rapid heartbeat, fear of new situations or people? If so, and these persist for more than a couple of weeks, you may be experiencing anxiety.

### Get support

The best thing you can do is ask for support. It is sometimes very hard to reach out, especially when you may be afraid of other’s reactions. My experience though is that families and friends can be remarkably compassionate; and studies have shown that people who have been involved in HIV patient care, as well as guideline development and studies on new HIV treatments, for many years. He had lots of support from work colleagues and friends in editing this article.

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Modernising ART

By Dr Michelle Moorhouse, Wits Reproductive Health and HIV Institute, and Southern African HIV Clinicians Society

Antiretroviral therapy (ART) in South Africa seems set for a revolution, with a new drug combination that is highly effective and involves only one pill a day that is smaller than an aspirin. One of South Africa’s top HIV clinicians explains...

South Africa, like many lower- and middle-income countries, follows the World Health Organisation (WHO) recommended public health approach, using standardised drug regimens to treat HIV. This, along with tasks shifting from doctors to NMART (Nurse Initiation and Management of Antiretroviral Therapy) trained nurses, has enabled more than 3.9 million people living with HIV (PLWH) to access life-saving antiretroviral therapy (ART) since 2003. ART is undeniably one of the biggest successes of modern medicine, along with vaccines and antibiotics.

While we have some pretty great treatments already, there is still room for improvement. Current first-line ART is a big pill to swallow and it has some unpleasant side effects, resulting in poor adherence and virological failure, and this is generally not tolerated; and it will not get any cheaper over time. From the more logistical aspect, the high dose of the drugs that make up first-line ART means they use more ingredients, meaning they cost more; this is also the reason the pill is so big, which in turn means the packaging is big, and takes up more space in the pharmacy. Clearly, we need treatments that are easier to take, in terms of size, and cheaper. And if you compare first-line ART in lower-middle-income countries (LMIC), some of the drugs being used are no longer recommended in better-resourced settings.

Current first-line ART

So, let’s look a little more closely at our current first-line ART, according to our national guidelines, most people living with HIV (PLWH) will receive a combination of efavirenz (EFV), tenofovir (TDF) and entecavir (ETV) or lamivudine (3TC) as first-line ART. FTC and 3TC, which are structurally almost identical, really contribute very little in the way of toxicity generally, and are usually continued through subsequent lines of therapy, so I am not going to say much more about them here; I’m going to confine my deliberations to EFV and TDF.

What is great about this combination is that millions of PLWH around the world have been treated with it for years, so there is a wealth of experience with it – a bit like that comfortable T-shirt we like to sleep in, for us as prescribers, but perhaps not so much for PLWH. The regimen has proven virological efficacy, is generally well tolerated, is simple to take as it is dosed once daily, and is co-formulated into a single tablet fixed-dose combination (FDC).

What are the problems with EFV?

It comes with some unpleasant side effects (abnormal dreams, nightmares, hallucinations even, and other neuropsychiatric-type symptoms, mainly; occasionally, rash); it has a very low resistance barrier; and it requires a high dose. Its safety in pregnancy has been established despite a bumpy start in early development, and it plays relatively well with most other drugs, including TB drugs (but not all; for example, some contraceptives, such as implants and IUDs). EFV is an example of one of the first-line drugs which has disappeared from first-line treatment in many wealthier countries.

Alternatives to EFV

So how do we improve on EFV? There are a number of alternatives to EFV to consider that are currently available in South Africa. Rilpivirine (RPV) is one option, from the same class of ARVs as EFV, and is dosed at 25mg (compared to 600mg of EFV which contributes significantly to the size of the FDC). RPV is much better tolerated than EFV and is incredibly cheap, which is always good news in a drug which could potentially be used to treat millions of people. The downside is that it is not yet available in any FDCs in South Africa, can’t be used with rifampicin-based TB treatment or in anyone with a high viral load when starting treatment, and in the public sector we don’t do viral loads at treatment initiation, so it too has its limits. However, it is being studied in some interesting new combinations, so let’s not set aside completely just yet. Certainly, as a switch option RPV is a very good choice in patients who don’t tolerate EFV, and there are studies which support this.

Dolutegravir (DTG) is another option already available in South Africa. Again, another low-dose drug, at 50mg. In registrational first-line studies, no-one with virological failure developed any DTG resistance, which means this drug is incredibly robust. DTG was also the first drug to ever beat EFV in a head-to-head study, where pretty much all others had previously tried and failed, and this was probably a lot to do with the fact DTG is more tolerable than EFV. And as the saying goes, if it sounds too good to be true… In fact, there are emerging data suggesting there may be some side effects, which include dizziness and anxiety. But this is coming mainly from European cohorts, which do not have the genetic diversity of African populations. Currently, there is a massive study called ADVANCE that compares DTG to EFV is under way in South Africa, and includes screening for these types of symptoms. DTG is also available in SA already co-formulated with abacavir (ABC) and 3TC, but it is not practical to roll out this particular FDC pragmatically, as ABC is very expensive.

But as DTG requires only a 50mg dose, if it were to be introduced into the public sector programme, produced by a generic manufacturer with South Africa’s buying power as the largest consumer of generic ART in the world, DTG would be an affordable option for first-line ART, and is currently an alternative option in the WHO guidelines. With regard to DTG and TB drugs, there is an interaction, which can be overcome by adjusting the dosing of the DTG; but this might not be necessary – some studies are under way to look into this. One of the current challenges with DTG is that at this stage, we don’t know a lot about DTG in pregnant women. Botswana made the bold move of introducing DTG into their HIV treatment programme in June 2016, including for pregnant women; and it is anticipated that they will present data on the first pregnancies at the IAS conference in Paris in July 2017, which will start to fill this gap. So, we have a very robust drug that is well tolerated and can be co-formulated into a small, inexpensive pill – looks promising.

Then there are also other future third-drug options which are not available in South Africa (or indeed anywhere else) as yet. These include doravirine and bictegravir. Doravirine is from the same class of drugs as EFV and RPV. It is still in phase 3 of development (registrational studies), and whether or not it will ever hit our shores is unknown. Bictegravir, also in phase 3, is a drug which is very similar to DTG and is co-formulated with tenofovir alafenamide fumarate (TAF), which I will discuss a little more below, and FTC.

An alternative to TDF

So, moving on to TDF: the problems with TDF are in some ways similar to those with EFV. The high dose means a high active pharmaceutical ingredient requirement, which drives up the pill size and the cost. And it also has some toxicity associated with it. Currently, we do not have any alternatives available in South Africa that are any better; but there is one which should be available soon, namely TAF (tenofovir alafenamide fumarate). TAF, like the TDF in current first-line ART, is a pro-drug of tenofovir. TAF is given at a much lower dose (approximately tenfold lower) than TDF. TAF is associated with much less kidney and bone toxicity than TDF. The ADVANCE study will also compare TAF and TDF, as most studies of DTG used ABC as the backbone, and also would not have included many African participants. TAF has not been studied with TB drugs or in pregnant women as yet, but these studies are under way. Once we have a better understanding of this, TAF is set to be a feasible option to replace TDF, on account of its better safety profile and lower dose, which will result in significant reductions in cost. And in fact, if DTG, FTC and TAF are co-formulated, potentially we are looking at a future first-line regimen, to quote Prof Francois Venter, “smaller than an aspirin”, which is incredibly potent, incredibly robust, incredibly well tolerated, all while being incredibly cheap – incredible, isn’t it?

ART does not exist in a vacuum

All of this is very important, while we have such tough targets to chase – the famous 90-90-90. And to achieve that third 90, we need to modernise treatments so that PLWH can adhere to them. When there are so many other challenges in a healthcare system, optimising ART to be as simple, safe, efficacious and robust as possible facilitates safer task-shifting to other cadres of staff, which may help alleviate some of the human resource shortages faced by healthcare facilities.

But no matter how good the drugs are, ART does not exist in a vacuum, and ART alone will not achieve the three 90s. ART will not fix the healthcare system. ART will not address stigma. ART will not help us achieve that first 90. 90% of PLWH knowing their status. ART will not find the missing in action to test them – the men, the key populations, the adolescents, girls and young women – and then link them to care to achieve the second 90. ART will not retain them in care, and measure their viral load so we can see if we are reaching that third 90.

Massive investment in infrastructure and development of systems, backed by political will, is critical. Civil society must remain engaged, and all of this must be backed by a National Strategic Plan (NSP) that is realistic, detailed, and which embodies the principles of equity and accessibility, and a commitment of work to be done to conquer HIV in South Africa, but optimised ART is certainly a great step in the right direction.
Following heavy rains in May, a malaria outbreak hit Limpopo. Clinics and other primary health facilities did not have enough testing kits or malaria treatment to deal with the outbreak.

Patients were therefore being transferred to Nkhsani Hospital. As there were too few beds, patients at the hospital were being admitted only to be left in an undignified condition on the floors of the wards. Immediately, TAC Limpopo organised a meeting with the CEO and Communications Manager of the hospital to address our concerns. The hospital acknowledged the challenges; in the interim, they erected tents to deal with the influx of patients. TAC kept the pressure on provincial government until resolution.

In July, Mopani district in Limpopo was facing a shortage of HIV-testing kits. After many calls from members of the public who had been unable to take an HIV test, TAC Limpopo escalated the matter to the District Health Department and the Office of the Mayor. The official response from the government was that the supplier’s tender had come to an end, and they had failed to calculate the risks and put measures in place to avoid a stockout. Following TAC’s intervention, limited stock was quickly delivered to Giyani Health Centre, Nkhsani Hospital, and Thomo Clinic. Shortly afterwards, TAC Limpopo received a call from Giyani Health Centre extending their gratitude for our intervention in the matter. The situation must be resolved urgently at the other facilities, to ensure that HIV testing can resume.

KwaZulu-Natal

In May, it came to light that KwaZulu-Natal’s healthcare services are in a state of emergency, with shocking details shared by health workers in the province.

Reports reflected a collapsing health system which is in many cases no longer delivering adequate healthcare to the most vulnerable. Hospitals are experiencing shortages of life-saving medicines and equipment, and suffering through departments that are entirely depleted of staff. Major delays for treatment and care continue to be felt in oncology and various other departments. In June, TAC KZN met with MEC of Health Dr Sindisivane Dhlomo, and raised these issues. In response, the MEC complained of cost cutting and budget cuts by the provincial Treasury. The response of the MEC failed to alleviate the concerns of TAC KZN. A suitable turnaround measures in place to avoid a stockout. Following TAC’s intervention, limited stock was quickly delivered to Giyani Health Centre, Nkhsani Hospital, and Thomo Clinic. Shortly afterwards, TAC Limpopo received a call from Giyani Health Centre extending their gratitude for our intervention in the matter. The situation must be resolved urgently at the other facilities, to ensure that HIV testing can resume.

The evidence is clear that earlier treatment reduces serious adverse events, such as TB and various cancers. Adhering properly to HIV treatment is critical to staying healthy. Additionally, this will also help prevent many new HIV infections. Studies show that people who are stable on treatment with undetectable viral loads are highly unlikely to transmit HIV to their sexual partners. The dysfunction in the public healthcare system creates its own challenges for people to remain adherent. The reality is that our clinics are in crisis. People must wait in long queues for hours to get their HIV treatment. Sometimes medicine stockouts or shortages mean people leave empty-handed. This forces people to default, and puts their health and lives at risk. Students must take the decision to miss classes in order to visit the clinic; those staying in residence must travel home to collect their treatment. Our rights to health care are under attack.

The UCAT said that whenever they went on the road to check on the status of life-saving medicines and staff at the various healthcare facilities, they were met with incompetence and lack of urgency.

TAC KZN has been working on a campaign to ‘Help Teens Protect Themselves’. Through our engagements with the MEC of Health and the MEC of Education, and the KZN Provincial AIDS Council, TAC KZN has been advocating for better access to prevention methods, the roll-out of prevention and treatment literacy training, and easier access to treatment, including on campuses. Both MECs made a clear commitment to improve youth-targeted HIV interventions. Now it is important for TAC KZN to monitor the roll-out. Treatment accessibility must be coupled with counselling and adherence support on campus. We also urge the University of Zululand to provide easy access to preventative measures such as male and female condoms, as well as pre-exposure prophylaxis (PrEP). PrEP aimed at young people and the general population should not be forced to enter buildings reserved only for collecting HIV medicines, and their clinic files must not be colour-coded or marked to show their status. TAC KZN will monitor the roll-out and advocate for other campuses to adopt this approach.
**Mpumalanga**

“Police in Ermelo used to assault, insult and arrest us often,” says Boitumelo, a sex worker from Mpumalanga.

“They would arrive at our houses, kick stuff, call us names, beat us. They would confiscate our medications (including HIV treatment), destroy our foods, ruin our furniture, even take our condoms. And after they had arrested us, we would spend the entire weekend in the dirty, smelly, and cold cell. Sometimes we would be released on the Monday with R500 each. Then we would appear in court where eventually the charges would be dropped.”

Boitumelo and other sex workers in the Ermelo area have been victimised by the police for years. After a chance meeting in the mall with a member of NAPWA – who happened to be wearing a T-shirt saying ‘sex work is work’ – Boitumelo and other sex workers were soon introduced to TAC Mpumalanga. In late 2015, TAC and partners escalated the matter to the MEC of Health, Gillian Mashego. They wrote to the MEC and the Brigadier of the SAPS to demand a meeting. The police had previously refused to meet, but engaged once the MEC was involved. In the meeting, after hearing the issues, the MEC demanded that the police stop harassing the sex workers and stop taking their condoms and medications. While the police tried to deny all that the sex workers said, photographs of beaten bodies, destroyed homes, and medications thrown on the floor, shocked the attendees of the meeting. The MEC instructed the police to engage with all departments and ensure that the victimisation and harassment would finally end.

“Since October 2016 we have not had problems with police. Since the police vans are no longer coming to our place, even clients come freely, and business has been better. Now I can at least send some money to my kids.”

Since last year, KwaMihlangu Hospital in Mpumalanga has been facing a severe crisis. A shortage of staff meant that doctors in the facility repeatedly went on strike. They were overworked, without the power to attend to all those in need of medical care. The maternity ward was overcrowded. Women would deliver their babies, after which they would be moved to a chair to sit for six hours observation, and then be sent home. Bloody and wet sheets would remain, as the next to give birth would occupy them. The nurses had no gloves or gowns; their clothes were dirty from delivering babies. The intensive care unit (ICU) was empty – no furniture, beds, or medical equipment; an abandoned, empty space. Conditions were untenable. At the district People’s Health Assembly organised by TAC in 2016, many complaints of poor service at KwaMihlangu were made, with members of the District Health Department in attendance: reports of people dying unnecessarily; people waiting months for simple procedures. The situation was so bad that even the National Portfolio Committee on Health visited the province and gave a damning report, which lead to the notorious threats made against MP Dr Makhozi Khosa.

TAC Mpumalanga met with the Hospital CEO to raise the various challenges that had been reported to us. The matter was escalated to the District Health Department, and then the Provincial Health Department. A meeting with Gillian Mashego, the MEC of Health, led to the removal of the CEO. An interim CEO was appointed in February 2017, after which the hospital received an injection of two million rand. The maternity ward was extended into a portion of the ICU to relieve the burden on the overcrowded ward, and a new position to manage this maternity ward has been advertised. The interim CEO visited hospitals in the North West to benchmark and gain guidance as to how to turn the crisis around. Some stability has finally been found, TAC will monitor the situation, and continue engaging with the new MEC.

* Not her real name – changed to protect her identity.

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**Western Cape**

For a long time, TAC Western Cape received complaints about Michael Mapongwana Community Health Clinic in Khayelitsha.

Parents with children and babies would be seen in a container at the back of the clinic. They would wait outside for long periods, whatever the weather conditions, to be attended to by health workers. They would have to undress their children outside because of a lack of space on the inside. Children with illnesses shared the same space with those attending post-natal check-ups. Late last year, TAC Western Cape held a picket outside the clinic, and met with the Health Department to address these concerns. Finally, in February 2017, following pressure from TAC, a new structure was opened that could accommodate the children in a dignified and appropriate manner.

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**Eastern Cape**

Since 2016, TAC Eastern Cape had received numerous complaints from the Clinic Committee and community members fearful of accessing health services at Philani Clinic. Mostly this was due to the bad attitude and lack of respect shown to patients by one of the nurses.

This nurse had repeatedly and publicly disclosed people’s HIV status and other health conditions without their consent. The situation had left community members not wanting to use the clinic at all. While the Mayor had proposed suspending the nurse in question pending a disciplinary hearing, the Sub-District Health Manager undermined this decision. The community were understandably angry at the change. In April 2017 they shut the clinic down in protest, locking its gates until the matter was resolved. According to the community, the clinic would only be reopened given the removal of the nurse. This meant no-one could access services at all. Worryingly, TB and drug-resistant TB patients in the area could not undergo treatment reviews, as their folders were locked inside the clinic. They had no option but to use another facility, given that the nearest TB hospital is 55km away.

TAC Eastern Cape and the Queenstown Council of Churches urgently mobilised the Clinic Committee, community organisations, churches and partners in the area to meet in Queenstown and come up with a strategy to re-open the clinic, to ensure people could access health care. TAC met with MEC of Health Phumza Dyantyi and Clinic Committee members to demand a way forward. After this pressure, the clinic was re-opened in June 2017, and the nurse was removed.

While one battle was won, the clinic is now understaffed, with one nurse being dismissed and one more resigning. TAC Eastern Cape will continue to demand that the vacant posts are filled urgently.
Free State

TAC Free State hears many complaints of medical negligence, and endeavours to assist people in getting the healthcare they need and deserve. One incident in Botshabelo involved Samuel Selebedi, who was bleeding profusely after falling onto a glass bottle.

After attending the clinic, he was rushed to Botshabelo Hospital. A painful surgery was conducted to stitch the bleeding arm, but doctors failed to remove the glass that had been lodged inside. No X-ray was taken. Mr Selebedi was sent home. Two months later, he faced complications. When he returned to Botshabelo Hospital, no one attended to him. He then visited a private health practitioner, who was the first person able to explain what had gone wrong. The doctor advised him to return to the hospital, to demand surgery to remove the glass from his arm. At this point, TAC Free State were contacted for support. TAC Free State accompanied Mr Selebedi to the hospital, supporting him to advocate for his right to health. The matter was escalated to the CEO of the hospital. Finally, a thorough surgery took place, and the glass was removed. TAC Free State will continue to support Mr Selebedi as he raises a case of medical negligence against the hospital, and will hold the CEO to account in ensuring no other cases of negligence occur.

In a landmark judgment in November 2016, with important implications for the right to protest in South Africa, the Bloemfontein High Court set aside the convictions and sentences of the 94 community healthcare workers (CHWs) known as the #BopheloHouse94. This finally brought to an end the state’s callous and vindictive persecution of this courageous group of mostly elderly women. The #BopheloHouse94 are CHWs from across the Free State. They were arrested in June 2014 at a peaceful night vigil at Bophelo House, the headquarters of the Free State Health Department. They were protesting the collapse of the Free State public healthcare system, and the April 2014 decision of then MEC of Health, Dr Benny Malakoane, to dismiss without warning or cause approximately 3 000 CHWs in the province. Malakoane has recently been removed as MEC of Health.

Since the judgment, TAC Free State has been engaging with the new MEC of Health, Butana Komphela. Not only have they been advocating for the reinstatement of the CHWs. A Memorandum of Understanding is in development that will ensure that TAC Free State will meet with the MEC of Health quarterly, and continue to monitor the state of health care in the province.

In March, community members phoned TAC Gauteng outraged and concerned after watching a white pick-up truck dump medical waste near the taxi rank in Mamelodi. Tablets, capsules, loose powder, syringes, pregnancy tests, HIV tests and office papers were strewn across the ground. TAC Gauteng launched a fact-finding mission into the state of hospitals across the province. Not only are they monitoring the state of the infrastructure but also the state of service delivery. Are there enough doctors, nurses, porters and security guards? Are people sent home without medicines? How long must people wait to be seen in these facilities? Are the facilities clean? Are there enough beds? Do people get the service they need?

On 16 March, TAC Gauteng met with MEC Ramokgopa for the first time. They are committed to engaging with her constructively to bring an end to the crisis in the public healthcare system. In addition to other issues, they raised concerns over the state of facilities. TAC Gauteng urged MEC Ramokgopa to undertake an urgent audit of health facilities across the province, the results of which must be made public, together with a plan to address any failings. The department must strengthen the Infrastructure Unit (in conjunction with the Department of Public Works) to address backlog maintenance, routine maintenance and the building of new health facilities – as well as ensuring better monitoring and oversight of material procurement processes – in order to prevent any further disasters in our health facilities.

Since 2012, TAC Gauteng have been complaining for years about the state of health facility infrastructure in the province. A report issued by TAC and SECTION27 at the time highlighted issues including the poor condition of buildings, cuts to the health facility revitisation grant, the onus is on MEC Ramokgopa to ensure enough money is allocated to provide funds for the many needed repairs. The Gauteng provincial Treasury may cut the health facility allocation, reducing the funds available for the maintenance of existing infrastructure and the development of new facilities under construction. This would be disastrous for health facilities and the people they serve.

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Especially alarming were reports that doctors at Charlotte Maxeke Hospital have been complaining for years about the structural problems. Even worse is that they felt the need to remain anonymous in making these reports. In our meeting, we urged MEC Ramokgopa to ensure a new era of openness, engagement and accountability from the provincial health department. No healthcare worker should fear victimisation or lack of job security as a result of speaking out. In order to ensure better communication flows, accountability, structures such as hospital boards and clinic committees should be fully functional, to ensure the concerns of health workers and community members are addressed effectively. A system should be established to take management teams out of their offices and into the community to listen to the needs of the people on a regular basis.

Proper maintenance of existing infrastructure and the development of more suitable infrastructure is essential to ensure safety, suitability, cleanliness and the proper functioning of facilities across the province. While Treasury may cut the health facility revitisation grant, the onus is on MEC Ramokgopa to ensure enough money is allocated to provide funds for the many needed repairs. The Gauteng provincial Treasury may cut the health facility allocation, reducing the funds available for the maintenance of existing infrastructure and the development of new facilities under construction. This would be disastrous for health facilities and the people they serve.

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**Spotlight on Health MECS**

**Spotlight profiling all nine of South Africa’s provincial Health MECS. We kick off with a look at freshly-appointed (and recycled) Gauteng Health MEC Gwen Ramokgopa, and Limpopo Health MEC Dr Phophi Ramathuba.**

**Take two for Granny Gwen**

By Ufrieda Ho

Governess’s merry-go-round of political appointments saw Gwen Ramokgopa return to the position of MEC for Health in Gauteng in February – a post she first held in 1999.

It couldn’t have been worse timing for Ramokgopa. She inherited the post vacated by her predecessor, Mahlangu, months after the aftermath of the shameful tragedy of the deaths of at least 94 mental health patients released from Life Esidimeni. They were among the approximately 1998 mentally disabled patients released to 27 non-governmental organisations (NGOs).

Her return in office would reveal that the number of deaths was in fact over 100. As of the beginning of March, 789 of the original 1998 patients discharged from Life Esidimeni were known to be at 22 NGOs, according to health department records. The whereabouts and details of those still unaccounted for remain a glaring concern, and the focus of investigations.

Ramokgopa’s public pledge at the time of taking over the portfolio was “to make the most vulnerable among us, to ‘reflect on this experience, as difficult as it is, and find ways to restore the confidence of our people in our health system’. She spoke of transparency as being important as she tackled the fallout of the crisis. However, weeks after Spotlight went through several official channels, Ramokgopa remained unavailable for interview – her communications were her priority; but open repeated requests for an interview.*

Ramokgopa had made to the Mukhari Hospital, to Dr George Mukhari Hospital. Through with renaming Ga-Rankuwa Hospital, to Dr George Mukhari Hospital. Renamed Tshwane. She also pushed ahead with renaming Ga-Rankuwa Hospital, to Dr George Mukhari Hospital. Renamed Tshwane. She also pushed ahead with renaming Ga-Rankuwa Hospital, to Dr George Mukhari Hospital. Renamed Tshwane. She also pushed ahead with renaming Ga-Rankuwa Hospital, to Dr George Mukhari Hospital. Renamed Tshwane. She also pushed ahead with renaming Ga-Rankuwa Hospital, to Dr George Mukhari Hospital. Renamed Tshwane. She also pushed ahead with renaming Ga-Rankuwa Hospital, to Dr George Mukhari Hospital. Renamed Tshwane. She also pushed ahead with renaming Ga-Rankuwa Hospital, to Dr George Mukhari Hospital. Renamed Tshwane. She also pushed ahead with naming her predecessor, Mahlangu, had taken off instead, though it was always linked to healthcare-related portfolios. Before returning to the role of Gauteng MEC, she was deputy health minister between 2010 and 2014. In 2015 the Tshwane University of Technology (TUT) appointed her its chancellor. They lauded her as “a woman of stature, a visionary who is passionate about success and excellence in every cause she commits to”.

The institution also outlined some of her achievements; she is no stranger to firsts, having been the inaugural CEO of the South African Medical and Dental Practitioners Association, and the first woman MEC for Health in Gauteng Province. Her return to the role of Health MEC will not be about firsts; most immediately, it will be about putting out the raging fires linked to the Life Esidimeni tragedy, and carrying out the recommendations from the Health Ombud’s findings into the death and suffering that occurred. Ramokgopa was quick to outline her plan of action – including her Rapid Intervention and Response Team, which has a dedicated reporting and assistance hotline (where someone does answer the phone, spotlight can confirm) that is expected to give weekly report-backs. She also announced an immediate halt to the deinstitutionalisation of mental health patients – a decision her predecessor, Mahlangu, had taken because, she said, the private-sector provider was costing too much. Ramokgopa also outlined plans to gather better data and information from patients and the families of the patients; vowed better consultation with families, and urgent assessment of the province’s mental health patients, so that if necessary they can be transferred from the NGOs to better care facilities.

At the time, she said: “I bemoan the fact that as a medical professional and an activist for a just society, together with millions of other South Africans, I could not foresee and thus intervene to prevent this tragedy as it unfolded.”

Ramokgopa stopped short of criticising Mahlangu. Citing ranks, she called Mahlangu “hard-working”, and commended her for her “integrity” in the financial management of the provincial department, which finally achieved an unqualified audit only in 2016.

In the meantime, the Economic Freedom Fighters, the Democratic Alliance and even the ANC Youth League had laid criminal charges against Mahlangu. Premier David Makhura had also suspended head of department Dr Barney Solombela. This was the raging fire into which Ramokgopa stepped. And her own appointment was met with immediate sniping from opposition parties. The DA’s Gauteng Health spokesman Jack Bloom called her “medusa”, judging from her first go at the portfolio in 1999, and said: “She does not have the drive to fix this deeply dysfunctional department.”

Previously, Gauteng Premier David Makhura had mapped out the enormous challenges faced by the department. In his report on the financial health of the province in August last year, he spoke of needing to lift the financial “cloud hanging over Gauteng” for over 10 years that had gathering over financial audits for the Department of Health ( till the unqualified 2015/2016 report).

He also pointed out the challenge of meeting the needs of “large volumes of people who come from other provinces to seek medical help in Gauteng”.

It is up to Ramokgopa to restore everyone’s massively damaged confidence in the Gauteng Department of Health, and to take forward the turnaround strategy the department outlined in 2014. It features eight core focus areas: financial management; human resource management and development; district health services for primary health care; hospital management; medico-legal services and litigation; health information management and systems; communication and social mobilisation; and health infrastructure management and development.

These are broad categories, with vast, complex names. Ramokgopa, returning to her MEC role 18 years later, will need to show that this time round she has the mettle, vision and mature leadership to get the job done. It will be about induciveness, transparency and action to radically transform the health department – not just about a high-profile cadre sent in to do a public-relations mop-up job for the political leadership. We watch with keen interest to see what Ramokgopa’s legacy will be on the Life Esidimeni tragedy. Will she be the MEC who held the perpetrators accountable or will her legacy be the MEC who failed to act.

*A request for face-to-face interaction with MEC Gwen Ramokgopa was first made on 21 February 2017. Khanyisa Ntura from the Department of Health took the call, and forwarded a follow-up email request to department spokesperson Prince Hamca. Hamca was also sent further emails and SMS messages, and was called numerous times. The editor of Spotlight also contacted Hamca separately to request interview time with Ramokgopa. Hamca did not respond or make any effort to suggest alternative ways to communicate with the MEC for the writing of this profile.*
Building health infrastructure – and Brand Phophi

By Ufreda Ho

It's a health budget day in Limpopo, and MEC Dr Phophi Ramathuba is set to address a packed council sitting in Lebowakgomo on how R18 billion will be divided up for health needs in the province.

It's Ramathuba's second year in the role, and it's a balancing act for a department that only came out of administration by national treasury less than two years ago.

Some in the gallery on the late summer day are clutching bottled water, and dressed like they've helped write an invite to the glitz party of the year.

There are severe staff shortages, and a glaring loss of experienced senior staff at facilities – many have been seduced by better pay and working conditions in private hospitals. There are regular reports of theft of medicines; shortages of essential equipment so dire, babies are said to have to share incubators; and ambulances are reduced to mortuary vans because they take forever to arrive, if they arrive at all.

There's also mismanagement and corruption at some facilities. Ramathuba's own unannounced spot visits at some of the province's hospitals during her tenure have revealed incidents such as patients going without proper meals, even when allocated provisions have been available.

She's also had to put out fires over corruption and scandal. In the days before the budget speech, the Democratic Alliance has flagged an outstanding financial debt owed to Cuba for the Cuban doctors programme that runs into millions. Cuban doctors are forcibly entrenched in Limpopo – this, even as their inability to understand local languages and local conditions is a cause of deep frustration for local patients.

There's also been a scandal involving a bogus hospital laundry contract for 12 hospitals in the province. It resulted in the Economic Freedom Fighters (EFF – the official opposition in the province) laying every manner of charge, including theft, even though it was a scandal she inherited. In response, Ramathuba took the decision to insource hospital laundry by introducing laundry minihubs. The financial recovery and planning for these are expected to be completed this financial year.

Corruption and inefficiencies in the system cost lives, especially in a province where the Department of Health says more than 80 per cent of the population is rural, and fully reliant on public healthcare. When local clinics prove to be hopelessly under-resourced, people are referred to hospitals. Often rural people means travelling long distances, at significant expense, to access treatment. Often they travel the night before their appointment, sleeping on hospital benches to secure a place in the queue to be seen by a doctor. Even then, sometimes the MEC has simply turned away before they receive any help.

Ramathuba should have first-hand understanding of the challenges of under-resourced rural life. She grew up in Limpopo's Vuwani, to parents who were teachers.

She has a good joke when she's reminded that when she delivered her budget speech, her cheeky joke about the mental health of some members of the legislature didn’t go unnoticed. Ramathuba demonstrated skill in being able to make her speech engaging and interactive – not just through the old jokes, but also by introducing some of her personal figures from life. These include young graduate doctors, part of Ramathuba's troop of 'super-specialists'. She's also had to put out fires over corruption and scandal.

The MEC has a modern touch in the way she stays connected. She uses social media effectively, and taps into issues like combating depression, fighting nypa use, and even ‘sexicide pastors’ is a touch of social-media genius.

In one of her Facebook picture she's in traditional Xitsonga dress. It garners comments such as “looking gorgeous”, and “just beautiful honourable”. She's also seen, in official pictures promoting a vaccination campaign, in a doctor's white jacket. There are pictures of Ramathuba on her Facebook page, her two daughters at an ANC Christmas and New Year babies, as well as images of her in meetings tackling a malaria outbreak; she's posted selfies taken in the legislature building, saying how honoured she felt to be Ramathuba’s special guest and calling the MEC a “brave leader”.

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She also holds a master's degree in advanced health management as well as other business and leadership qualifications.

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The MEC has a modern touch in the way she stays connected. She uses social media effectively, and taps into issues like combating depression, fighting nypa use, and even ‘sexicide pastors’ is a touch of social-media genius.

In one of her Facebook picture she's in traditional Xitsonga dress. It garners comments such as “looking gorgeous”, and “just beautiful honourable”. She's also seen, in official pictures promoting a vaccination campaign, in a doctor's white jacket. There are pictures of Ramathuba on her Facebook page, her two daughters at an ANC Christmas and New Year babies, as well as images of her in meetings tackling a malaria outbreak; she's posted selfies taken in the legislature building, saying how honoured she felt to be Ramathuba’s special guest and calling the MEC a “brave leader”.

She's a woman who's found her way to the top, and she does so in a way which makes you want to buy a magic wand over entrenched problems in the province; it’s more to do with her approach: staying connected, being seen, and making a difference. She's a woman who's found her way to the top, and she does so in a way which makes you want to buy a magic wand over entrenched problems in the province; it’s more to do with her approach: staying connected, being seen, and making a difference. She's a woman who's found her way to the top, and she does so in a way which makes you want to buy a magic wand over entrenched problems in the province; it’s more to do with her approach: staying connected, being seen, and making a difference. She's a woman who's found her way to the top, and she does so in a way which makes you want to buy a magic wand over entrenched problems in the province; it’s more to do with her approach: staying connected, being seen, and making a difference.
NSP in brief

On 11 May 2017, after multiple delays, South Africa’s National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022 was finally published. The NSP is meant to coordinate and guide a coherent response from government, business, organised labour and civil society to the HIV and TB epidemics in South Africa.

What is in the NSP?

**NSP targets**
The NSP contains a number of targets that South Africa must meet by 2022. Below we list only some of these targets:

- The NSP aims to reduce new HIV infections in South Africa to under 100,000 per year by 2022. Currently there are around 270,000 new HIV infections per year.
- The NSP endorses the UNAIDS 90-90-90 targets for HIV - although the NSP sets these targets not for 2020 as UNAIDS does, but two years later, in 2022. These targets say that 90% of people with HIV must know their status, 90% of people who know their status must be receiving treatment, and 90% of people on treatment must have undetectable viral loads.
- 85,000 people in South Africa must receive pre-exposure prophylaxis for HIV by 2022. In earlier drafts of the NSP this target was much higher, at 1.4 million.
- The NSP also endorses the Global Plan to End TB’s 90-90-90 targets. These targets say that 90% of people with TB must be diagnosed and receive appropriate treatment, 90% of people with TB in key and vulnerable populations must be diagnosed and receive appropriate treatment, and treatment must be successful in at least 90% of these people.

**Eight goals**
The NSP identifies eight key goals:

1. Accelerate prevention to reduce new HIV and TB infections and STIs. 2. Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all. 3. Reach all key and vulnerable populations with customised and targeted interventions. 4. Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP. 5. Ground the response to HIV, TB and STIs in human rights principles and approaches. 6. Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs. 7. Mobilise resources to support the achievement of NSP goals and ensure a sustainable response. 8. Strengthen strategic information to drive progress towards achievement of the NSP goals.

**Critical enablers**
In addition to the eight goals, the NSP also identifies five ‘critical enablers’:

1. Focus on social and behaviour change communication, to ensure social mobilisation and increasing awareness. 2. Build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics. 3. Effectively integrate HIV, TB and STI interventions and services. 4. Strengthen procurement and supply chain systems. 5. Ensure that the human resources required are sufficient in number and mix, and trained and located where they are needed.

**Strengths of the NSP**

1. The NSP proposes an ambitious new HIV Counselling and Testing campaign that goes beyond the healthcare system and includes HIV self-testing.
2. In principle, the NSP supports more aggressive efforts to diagnose people with TB more quickly through contact tracing and active case-finding. Whether government will make the human resources available to realise this commitment is unclear.
3. The NSP commits to the rapid introduction of new treatments and tests for TB. This is especially important, since new TB tests and treatments for drug-resistant TB and latent TB are very likely in the next five years.
4. The NSP commits to the introduction of a unique patient identifier. This means that every person will have a unique number that they can use to access their file when moving from one clinic to another, or when moving from prison back into the community.

**Weaknesses of the NSP**

1. While there are many good things in the NSP, it does not provide enough guidance to provinces on how to implement the NSP. Much of the success of the NSP will depend on the development of realistic and implementable Provincial Implementation Plans.
2. The NSP sets very low targets for pre-exposure prophylaxis for HIV. This makes a mockery of all its rhetoric about HIV prevention.
3. The NSP fails to make a clear and unambiguous case for the decriminalisation of sex work.
4. The NSP fails to make the human resource crisis in the public healthcare system. It fails to clearly acknowledge that implementing the NSP will be impossible without more healthcare workers and other human resources in the healthcare system.
5. Much of the success of the NSP will depend on the development of realistic and implementable Provincial Implementation Plans. Since the NSP is weak when it comes to implementation, this will be a difficult task for provinces.
6. The NSP is too vague on the human resource crisis in the public healthcare system. It fails to clearly acknowledge that implementing the NSP will be impossible without more healthcare workers and other human resources in the healthcare system. It is especially disappointing that the NSP does not commit to the employment of specific numbers of community healthcare workers.
7. While the NSP talks about accountability, it provides no concrete and realistic means by which accountability can be increased in the healthcare system.
8. The NSP sets very low targets for pre-exposure prophylaxis for HIV. This makes a mockery of all its rhetoric about HIV prevention.
The South African National AIDS Council (SANAC) has been in crisis since the beginning of 2017. The crisis relates primarily to governance at SANAC. Since millions of Rands meant to support South Africa’s HIV and TB response passes through SANAC, this governance crisis may result in donor funds not being distributed effectively and responsibly.

Perhaps more importantly, the governance crisis undermines SANAC’s ability to play a coordinating and guiding role between civil society, government, organised labour and business. With SANAC adrift, there is a risk that South Africa’s HIV and TB response may lose focus.

Key aspects of the governance crisis
1. Until recently, at least one of the members of the SANAC board of trustees has refused to sign declarations of conflicts of interest. That the board continued to function for multiple years without such declarations of interests being made by all board members brings into question the board’s commitment to good governance.
2. The board failed to deal firmly and transparently with a case in which a board member and civil society leader failed to disclose a series of business interests. The board allegedly approved a payment to a board member seemingly in contradiction of SANAC’s own rules. When questions were asked about this, the board failed to provide clear and transparent answers.
3. The board oversaw a highly contentious process for appointing a new SANAC CEO. Rather than extend the term of the previous CEO until such time as a new CEO could be appointed, an interim CEO was appointed. This change in CEO came at a critical time, when South Africa’s new National Strategic Plan for HIV, TB and STIs was being finalised. Six months later, the interim CEO is still in place.
4. Apart from the previous chair of the board stepping down to take up the role of Gauteng MEC for Health, two more board members have resigned in recent months.

Civil Society chair lied
One of the most controversial people at SANAC is Steve Letsike, the recently re-elected chair of the Civil Society Forum. Letsike is controversial for various reasons, including the following:
1. Letsike lied on record to Health-e News Service when she said through her lawyer that she is not in business with Dr Ramneek Ahluwalia.
2. Health-e had obtained documents from the CIPC showing that Letsike and Ahluwalia are joint directors of a company called Mediacliq.
3. Letsike and Ahluwalia’s company, Mediacliq, allegedly tried to win contracts from the Department of Health. They are also doing work for the KwaZulu-Natal Department of Health. Beyond Letsike’s claim that it is unpaid, we know hardly anything about this work. Either way, it presents a notable conflict of interest.

While none of the above amounts to outright proof of corruption, it raises a number of red flags, and must urgently be investigated. In response to a letter from the Treatment Action Campaign, SANAC head Deputy President Cyril Ramaphosa promised that an investigation would be conducted. Almost six months later, however, there is as yet no evidence that such an investigation is being conducted.
Tuberculosis (TB) is still a crisis in South Africa. Here are 10 things you need to know:

1. Tuberculosis (TB) remains a crisis in South Africa. It is the top cause of death indicated on death reports. There are over 400,000 cases of TB in South Africa per year. TB cases are slowly coming down, but it is not happening nearly fast enough.

2. One of the biggest problems with TB is that we do not diagnose people fast enough and get them on to treatment fast enough. This is bad for the health of people with TB, but also contributes to the spread of TB in our communities. Two potential solutions are active case finding (ACF) and contact tracing. ACF is when healthcare workers or community healthcare workers go out and look for people with TB. Contact tracing is when we trace the family and/or work contacts of someone with TB and then test them for TB as well. Most experts agree that government must invest more in ACF and contact tracing, but unfortunately government has not shown much ambition in this regard. This lack of ambition is probably because government does not want to employ more people.

3. Another critical problem in our response to TB is the poor infection control measures in most public spaces. In taxis, or in waiting rooms at clinics, or at Home Affairs offices, often the windows are not opened and all the people present breathe the same air. In addition, many prisons are overcrowded and create ideal conditions for the transmission of TB. Here too, government has not shown much ambition in dealing with the problem.

4. There are over 20,000 cases of drug-resistant TB (DR TB) in South Africa per year at the moment. It appears that the rates of DR TB are going up – something which surely constitutes a public health emergency. DR TB is much more difficult and more expensive to treat than normal TB. There is also evidence suggesting that most people with DR TB did not develop the drug resistance while being treated for normal TB, but were infected with TB that was already drug-resistant. Unfortunately, the rates of DR TB are slowly coming down, but it is not happening nearly fast enough.

5. Until recently, treatment for multiple drug-resistant TB (MDR TB) took two years, and often resulted in severe side effects such as deafness. However, the World Health Organisation recently recommended a new nine-month regimen with fewer side effects for the treatment of MDR TB. South Africa is in the process of introducing this new, shorter regimen.

6. While the new nine-month MDR TB regimen is an improvement on previous regimens, it still entails a large number of pills and injections, and has substantial risk of side effects. The good news, however, is that a number of trials are under way to test even shorter regimens that will contain no injections, and hopefully will have even fewer side effects. We should start seeing results from these trials in 2019.

7. Extensively drug resistant TB (XDR TB) is the most difficult form of TB to treat, and over 70% of people with XDR TB in South Africa die within five years. There is good news, however: an ongoing trial in South Africa called Nix-TB is showing much higher cure rates for XDR TB than we’ve ever seen before. In the Nix-TB trial, people are treated with three drugs: bedaquiline, pretomanid and linezolid.

8. While bedaquiline and linezolid are already registered and available in South Africa, pretomanid is not yet registered. Pretomanid is not being developed by a pharmaceutical company, but by a non-profit called the TB Alliance. Donors should work with the TB Alliance to make pretomanid available under compassionate-use concessions, so that people in South Africa with XDR TB can access the drug.

9. People living with HIV are at higher risk of contracting TB. For this reason, people are given isoniazid preventative therapy (IPT) to prevent the development of TB. For years IPT treatment rates in South Africa were very low, but recent figures suggest that many more people are now receiving IPT and being protected against TB. IPT works well and can be taken for six months or a year, or even longer. It consists of isoniazid and another drug called rifampicin. The IPT regimen involves taking pills only once a week, for a period of 12 weeks. If ongoing trials of 3HP in South Africa are successful, 3HP will replace IPT at some point in the next five years.

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TAC survey highlights poor infection control in clinics

By Marcus Low

Tuberculosis (TB) infection-control measures in some South African public-sector clinics fall woefully short of what is required. This is according to an infection-control survey that was published by the Treatment Action Campaign (TAC) ahead of World TB Day (23 March 2017).

While the survey has some limitations, and is by no means an exhaustive survey of clinics in South Africa, it nevertheless provides compelling evidence that we have an infection-control problem at a number of public-sector clinics. Given that poor infection control at clinics may be a significant contributor to TB transmission in South Africa, this is a red flag that should be taken seriously.

How was the survey conducted?

TAC branch members across seven of South Africa’s nine provinces were trained on a TB infection-control questionnaire. Delegations from TAC branches then went to their local clinics to fill in the questionnaires. They reported their findings back to the TAC national office, where the findings were captured. The questionnaire contained seven questions relating to TB infection-control measures that should be in place at clinics. Each question required a simple ‘yes’ or ‘no’ answer. The questionnaire was designed in such a way that ‘yes’ answers in each case indicated correct infection-control procedures. In other words, the more ‘yes’ answers a clinic received, the better.

What did the survey find? As part of their media release, TAC published an Excel file containing the data they had collected. This file contains details of the 158 clinics that were surveyed, and how each of seven questions was answered in relation to these clinics. Below we present some additional analysis we conducted of the data provided by TAC. (For those interested in exploring the data, we have done some data cleaning and saved the results as a CSV file that can be downloaded from https://www.dropbox.com/s/cho2s5ne57v2p7/TBI2.csv?dl=0.)

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWERED NO</th>
<th>ANSWERED YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>—are the windows open?</td>
<td>22</td>
<td>156</td>
</tr>
<tr>
<td>—is there enough room in the waiting area?</td>
<td>92</td>
<td>66</td>
</tr>
<tr>
<td>—are there posters telling you to cover your mouth when coughing or sneezing?</td>
<td>64</td>
<td>94</td>
</tr>
<tr>
<td>—are you seen within 30 minutes of arriving at the clinic?</td>
<td>101</td>
<td>57</td>
</tr>
<tr>
<td>—are people in the clinic waiting area asked if they have TB symptoms?</td>
<td>79</td>
<td>79</td>
</tr>
<tr>
<td>—are people who are coughing separated from those who are not?</td>
<td>105</td>
<td>53</td>
</tr>
<tr>
<td>—are people who cough a lot or who may have TB given tissues or TB masks?</td>
<td>116</td>
<td>42</td>
</tr>
</tbody>
</table>

Scores by province

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>NUMBER OF CLINICS SURVEYED</th>
<th>AVERAGE SCORE OUT OF 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>15</td>
<td>4.87</td>
</tr>
<tr>
<td>KZN</td>
<td>20</td>
<td>3.55</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>23</td>
<td>3.52</td>
</tr>
<tr>
<td>Free State</td>
<td>19</td>
<td>3.16</td>
</tr>
<tr>
<td>Limpopo</td>
<td>23</td>
<td>3.0</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>39</td>
<td>2.92</td>
</tr>
<tr>
<td>Gauteng</td>
<td>17</td>
<td>2.88</td>
</tr>
</tbody>
</table>

This table shows the average score of the clinics surveyed in each province – though we should stress that these are not representative samples, and the findings cannot be generalised to entire provinces. The mean scores for some provinces are also so close together that we should not read anything into the fact that, for example, Mpumalanga is rated higher than Gauteng, or that Free State scores higher than Limpopo. It does seem significant, however, that the clinics that were surveyed in the Western Cape tended to do substantially better than the clinics surveyed in other provinces. No clinics in the North West province or the Northern Cape were surveyed. Of the seven provinces surveyed, Mpumalanga is somewhat over-represented, with 39 out of the 158 clinics – most other provinces had around 20 clinics surveyed.

Results by question

This table shows the total ‘no’ and ‘yes’ answers to the seven questions. In each case, ‘yes’ indicates correct infection-control measures. Only questions 1 and 3 received more than 50% ‘yes’ answers. Question 5 received exactly 50% ‘yes’ answers.

How much did clinic scores vary?

The TB infection-control measure on which clinics performed the best was ‘keeping the windows open in the waiting area’. Second-best was ‘having posters up on the walls telling people to cover their mouths when coughing or sneezing’. However, apart from opening windows and having posters on the walls, most clinics did very poorly at TB infection control. It is also notable that on the cross-cutting question as to whether people are seen within 30 minutes, only 57 of the 158 clinics received ‘yes’ answers. A long waiting time becomes a more important risk factor when other infection-control measures are not in place, because people are exposed for longer periods. The average score in clinics with less than a 30-minute waiting time was 5.3, compared to only 2.3 in clinics with longer waiting times – in other words, the clinics where people waited longer tended to be the clinics where the risk of TB infection was already substantially higher.
Kholiswa Sondzaba was not only a fierce human rights activist, but she was also a beacon of hope to many members of the LGBTIAQ+ community in rural Eastern Cape. One could argue that her health struggles as a person living with HIV, seemed negligible in comparison to the stigma and discrimination she faced as a lesbian. On one occasion the traditional leaders refused Cool’s platform to engage other rural women on issues of HIV prevention and treatment access on the basis of what the chief referred to as a questionable and unacceptable gender identification. Cool’s never gave up and continued to associate herself with other activists in challenging culture, and how it was used to discriminate and allow space to perpetuate gender based violence among lesbian women through corrective rape. Although Cool’s is no longer with us, it is important that we reflect on the work that she has done, from treatment literacy, to being part of support groups, and ensuring people had access to their medication. The struggle clearly is not over yet and there is much work to be done in light of stigma and ultimately the dignity for all.

Cools left us on the 15th of June, after battling with illness. Until the very end Cools remained selfless. A true example of what it meant to be an activist and a comrade in arms. Rest easy Cools, you won your battle and we will continue the fight.

Thandiwe (TK) Sebeni was born on the 24th of May 1987, in rural Lusikisiki. TK was one of the first people in the community to disclose her sexual identity in the rural district of the Eastern Cape.

TK was an active member of the Treatment Action Campaign. When it came to ensuring that people had access to healthcare, TK was a force to be reckoned with. TK was one of the activists that took over Mthatha Pharmaceutical depot to ensure that essential medicines were delivered to people. And that is exactly what TK was all about. People. At the forefront of all the struggles she faced, she worked tirelessly to ensure that ordinary people on the ground would not be overlooked.

We are deeply saddened to have lost such a strong and committed leader, but we know TK will rest easy knowing that she played her part to the fullest. She left us on the 7th of July in 2017 after battling with opportunistic infections.

Rest in peace, comrades.

Some Spotlight articles are only published on the Spotlight website. Here are some of the highlights from the website in recent months:

**N HLS crisis continues**

The National Health Laboratory Service (NHLS) is a critical part of our HIV and TB response. Without a functioning NHLS, HIV viral load tests or TB tests will not be done. A recent crisis at the NHLS came to an end when NEHAWU called an end to a potentially debilitating strike. While the immediate crisis has been averted, the NHLS remains in very deep trouble. Mostly because Gauteng and KwaZulu Natal are not paying their NHLS bills, the NHLS is expected to run out of money by the end of the year. Keep an eye on the Spotlight website where we will be covering this impending disaster.

**Air ambulance scandal**

Earlier this year, Spotlight published an in-depth investigation into a series of controversial tenders for aeromedical services. Such aeromedical services involve flying injured or sick patients to hospital, or transporting medical staff to serve rural areas. While there is no smoking gun, the information we unearthed warrants a serious investigation.

**Special feature on CHWs**

There are many questions about how community healthcare workers (CHWs) should be employed, what they should be paid, what their scope of work should be, and how many are needed in South Africa. Sasha Stevenson of SECTION27 examined the available evidence, and produced a Spotlight special investigation that is essential reading for anyone interested in CHW policy in South Africa.

**New school HIV policy**

A new school HIV policy from the Department of Basic Education has theoretically opened the door to the wider availability of condoms in schools. However, a close reading of the policy raises some red flags. Kirsten Whitfield of SECTION27 unpacked the policy for us.

**Former SANAC CEO speaks out**

In recent months, Spotlight has published a number of articles on South Africa’s new National Strategic Plan for HIV, TB and STIs 2017-2022. These articles include an in-depth assessment of the NSF by Spotlight co-editor Marcus Low, and a must-read article by former SANAC CEO Dr Fareda Abdullah, in which he places the NSF in its proper context.

Read these stories and more at www.SpotlightNSP.co.za
WE VOTE FOR HEALTH NOT CORRUPTION.