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**An investigation into the 2007/08
Antiretroviral Treatment Programme of the
Eastern Cape Department of Health: A case
study of the Midland Hospital ARV Clinic**

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Introduction:

This research report scrutinises the Eastern Cape Department of Health's progress up until the end of August 2007 in implementing its 2007/08 Antiretroviral Treatment (ART) rollout programme as part of the HIV/AIDS and STI Programme. By focusing on one ART site in one Local Service Area (LSA) as an illustration of how this programme operates on the ground, the research will reveal the challenges, failures and accomplishments at the site of delivery, as well as what the needs at this crucial level of implementation are. This will be situated in the context of the Department's performance in this programme for previous financial years.

Aims:

This research report aims to illustrate the demands placed on health professionals and facilities, whilst also considering the needs of patients who access health care at this level. By focusing on one LSA, the needs of the programme and the need for the programme will be highlighted in the context of the fact that, at the provincial level, the Department is unaware of how many people in the province require ART. In order for the Department to conduct an assessment of such need throughout the province, it is necessary that the Department start at the LSA level and work up through the District level. This information should then be collated in order to establish the extent of ART treatment required by citizens who are infected. This would in turn assist the Department in setting targets and developing plans which would be more responsive to the needs of those persons who are reliant upon the Department's health care services.

Method:

This research report focuses on the Midland Hospital ARV Clinic (also known as iThemba Clinic) in Graaff-Reinet in the Camdeboo LSA of the Cacadu District in the Eastern Cape. The Midland Hospital ARV Clinic site was selected as it was accredited at the start of the 2007/08 financial year and had been reported as facing challenges in getting the ART programme off the ground.¹ Once the site had been identified, site visits were conducted and relevant stakeholders were interviewed. This included attending the ARV stakeholder monthly meetings; interviewing the CEO of the Hospital, the LSA HIV/AIDS and STI Programme members and the Assistant Director of the ARV Clinic; and conducting site visits to two of the feeder clinics in the outlying areas and interviewing the nurses at these clinics. Interviews were also requested of the Cacadu District Health Manager and the HIV/AIDS Programme manager, but these were declined.²

Input into this research obtained via interviews with individuals employed at the Camdeboo LSA and Midland Hospital must be viewed by the Eastern Cape Department of Health, as it is by the PSAM, as constructive and illustrative of the challenges faced in implementing the ART Programme. This information was not intended to bring the Department into disrepute, but rather was provided to bring about continued improvement in ART and health care provision. The PSAM wishes to record that the information obtained during these interviews is the kind of internal consultation and

¹ 'No ARVs in Graaff-Reinet', *Health-e news*, 16 May 2007. Available at <http://www.health-e.org.za/news/article.php?uid=20031656>

² The interviews were declined because of work pressure and resultant unavailability on the part of the two officials who also indicated that the necessary information could be obtained from the Camdeboo LSA HIV/AIDS and STI Programme staff.

unpacking of issues and bottlenecks that must continually occur within the Department in order for it to draw up plans that address the challenges highlighted by health workers. The Department should foster an environment where this kind of discussion and consultation is encouraged. While the names of the individual staff members interviewed have been omitted, their positions are stated and thus it is imperative that these staff members are not victimised by the Department.

Further documentation regarding the budget for this programme was requested and received from the Provincial and National Department of Health. Other relevant documentation was also sourced from the Midland ARV Clinic, while provincial documents relating to the ARV programme were used to provide the background to the research and to locate the case study of the Midland ARV Clinic within the broader context of the province.

Limitations:

This research report is limited in that it only illustrates the experiences of one ARV clinic in the Eastern Cape. However, while the information presented here may be regarded as anecdotal, it does serve to illustrate bottlenecks and challenges in the programme that in all likelihood are not specific to this area alone, but may be illustrative of province-wide phenomena, and thus serves as an in-depth look into these issues which are relevant to other sites across the province.

Context:

According to the HIV and AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP), about 5.54 million South Africans were living with HIV in 2005, with 18.8 % of the adult population (15-49 years) and 12% of the general population being infected.³

According to the NSP, approximately 230 000 HIV-infected individuals were receiving antiretroviral treatment nationally in 2006⁴, while according to data provided by the National Department of Health's head of the HIV/AIDS Programme⁵, a total of 257,108 patients were accessing ART in the public sector as of April 2007.⁶ The NSP further states that there were 540 000 people who were sick with AIDS in 2006 but not receiving treatment.⁷ In contrast, government reports estimate that there are only approximately 30 000 people on official waiting lists.⁸ Not surprisingly then, given the number of people who should be receiving ARVs and are not, as outlined above, it was estimated that in 2006 approximately 350 000 deaths were due to AIDS in South Africa, amounting to 950 AIDS-related deaths per day.⁹

³ HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP), p. 7

⁴ HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP), p. 43

⁵ As stated in Hassan, F. "South Africa" in Missing the Target # 4, 18 July 2007, International Treatment Preparedness Coalition (ITPC), p. 104. Available at <http://www.aidstreatmentaccess.org/itpc4thfinal.pdf>

⁶ It is estimated that up to a third of these patients are supported by NGOs and donors such as PEPFAR, Absolute return for Kids (ARK) and Medicines Sans Frontiers (MSF). Ibid.

⁷ HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP), p. 43

⁸ As stated in Hassan, F. "South Africa" in Missing the Target # 4, 18 July 2007, International Treatment Preparedness Coalition (ITPC), p. 104. Available at <http://www.aidstreatmentaccess.org/itpc4thfinal.pdf>

⁹ HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP), p.42

Given the above-mentioned challenges the National Department of Health currently faces regarding ART roll out, the targets as set out in the NSP are starkly ambitious. The key priority area of treatment, care and support as outlined in the NSP sets its target to “provide an appropriate package of treatment, care and support services to 80% of people living with HIV and their families by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV and AIDS.”¹⁰ However, according to the figures in the NSP as outlined above, of the 770 000 people who need treatment, only 29% are receiving it through the public health care system.

Background: An overview of HIV/AIDS treatment in the Eastern Cape

By the end of the 2006/07 financial year the Eastern Cape Department of Health had 28 382 patients registered for ART in the Eastern Cape.¹¹ Of these, 8 086 were adult males, 18 000 were adult females and 2 296 were children. The targets for the 2007/08 financial year are to have 40 000 patients registered for ART, with 11 200 adult males, 25 200 females and 3 600 children.¹²

However, the Eastern Cape Department of Health reports that during 2006/07 there were 12 388 patients who were medically eligible for ART on the waiting list.¹³ This means that the Department was not providing treatment (at a minimum) to 30% of people who required treatment that the Department knew of. In addition, the Eastern Cape Department of Health informed the PSAM that, as at the end of June 2005, there were already 30 851 patients on the ART waiting list who were eligible for the treatment.¹⁴ This means that even though the Department reached its target of 27 000 patients by the end of March 2007, it still did not address the patients awaiting ART as of June 2005. This figure does not take into account the number of people who are turned away at Primary Health Care facilities due to capacity constraints and thus cannot be tested for HIV to assess whether ART is necessary.¹⁵ Moreover, of the total number of 64 096 deaths in the Eastern Cape in 2006, AIDS accounted for 38 507 or 60 % of these.¹⁶

According to the National HIV and Syphilis Prevalence Survey for 2006, the prevalence rate in the Eastern Cape was 28.6%.¹⁷ According to The Demographic Impact of HIV/AIDS in South Africa Study for 2006, there were 54 000 HIV-positive people in the

¹⁰ Ibid, p. 59

¹¹ HIV & AIDS & STI's 2007-2008 Business Plan, Eastern Cape Department of Health, p.19

¹² Ibid.

¹³ Ibid.

¹⁴ Letter from Eastern Cape Department of Health, RE: Request for current ARV Roll-out statistics, 22 June 2006

¹⁵ At the Primary Health Care Level, patients are reportedly being turned away at clinics due to the high staff-patient ratios at these clinics. Interview HIV & AIDS & STI Programme Manager for the Camdeboo LSA, Graaff-Reinet, 30 August 2007.

¹⁶ Dorrington, R.E., Bradshaw, D., Johnson, L. and Daniel, T. 2006. The demographic Impact of HIV/AIDS in South Africa. National and Provincial Indicators 2006. Cape Town: Centre for Actuarial Research, South Africa Medical Research Council, Actuarial Society of South Africa, p.

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¹⁷ National HIV and Syphilis Prevalence Survey South Africa 2006, Department of Health 2007, p.

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Eastern Cape at Stage 4 of infection, and hence in need of ART, who were not on treatment.¹⁸

The Eastern Cape Department of Health's 2007/08 ART target of having 40 000 patients on treatment appears to be based on the sum of the number of people on treatment in 2006/07 (28 382) and those on the waiting list (12 388), which is 40 770. This is highly problematic as this does not take into account the fact that the number of people needing ARVs would have grown substantially given the 2006 HIV incidence rate of 1.3%.¹⁹ The Department needs to conduct adequate research into how many people in the province require ART and to set their targets accordingly.

Of most concern is that, in the Eastern Cape, around a third of infected people are in the first stage of infection. This indicates that the epidemic in the province is still emerging and thus the full burden of the disease on the health system and the province has not as of yet been felt.²⁰ Given the current challenges of ART rollout in the Eastern Cape this is of grave concern, and speaks to the need for a re-evaluation of the Eastern Cape's current plan to administer ART in line with the targets as set out in the National HIV & AIDS and STI Strategic Plan for South Africa 2007-2011.

2007/08 Eastern Cape HIV & AIDS Budget:

Budget Allocations:

The Eastern Cape Department of Health's HIV and AIDS programmes receive their budget allocation from the provincial equitable share as well as the Comprehensive HIV and AIDS Conditional Grant. According to the Division of Revenue Act of 2007, the purpose of the Comprehensive HIV and Aids Conditional Grant is to "enable the health sector to develop an effective response to the HIV and Aids epidemic and other matters". Of the total R1.94 billion being transferred to provinces from the National Department of Health, R233.20 million will be allocated to the Eastern Cape Department of Health during the 2007/08 financial year, which is the third highest allocation amongst the nine provinces.²¹ This is an increase of 0.49 % in nominal terms, up from R232.07 million received in 2006/07 to R233.20 million in 2007/08.²² In real terms, this is a decrease of 4.39 % from 2006/07 to 2007/08. This real decrease in allocation is worrying given that the Eastern Cape Department of Health overspent its Comprehensive HIV and AIDS grant by 19.9 %, or R45.79 million in 2006/07.²³ This clearly demonstrates the need to increase rather than decrease real allocations for this vital grant.

¹⁸ Dorrington, R.E., Bradshaw, D., Johnson, L. and Daniel, T. 2006. The demographic Impact of HIV/AIDS in South Africa. National and Provincial Indicators 2006. Cape Town: Centre for Actuarial Research, South Africa Medical Research Council, Actuarial Society of South Africa, p.35

¹⁹ The HIV Incidence Rate is the percentage of people who are uninfected at the beginning of the period who will become infected over the twelve months. This does not indicate an increase in the number of people in need of ARTs but does however indicate that the number of people being infected is growing annually, and hence these newly infected patients are developing from Stage 1 to Stage 4 in the disease over time and thus require treatment. Ibid, p. 35

²⁰ Ibid, p.29

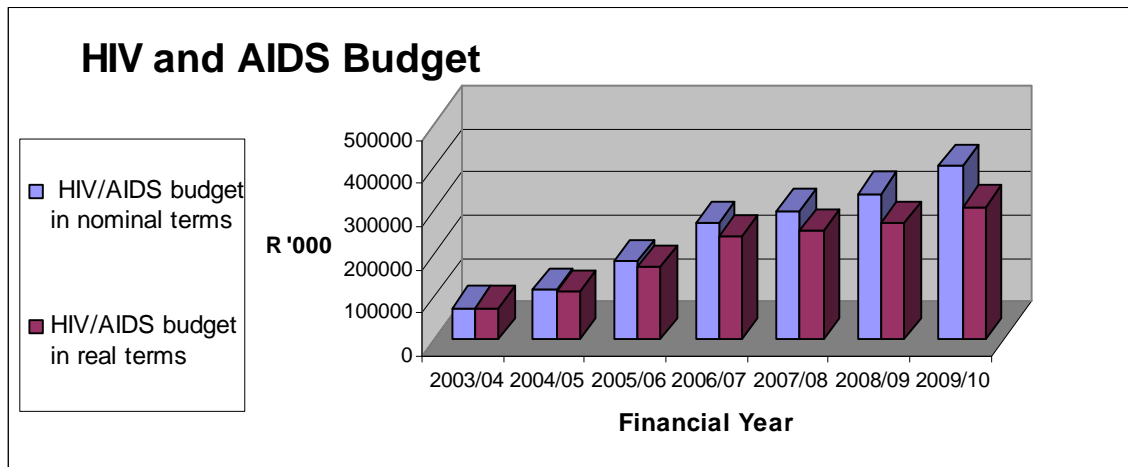
²¹ Division of Revenue Act 2007, Government Gazette, 31 March 2007, p. 77, Available at <http://www.info.gov.za/gazette/acts/2006/a2-06.pdf>

²² Eastern Cape Provincial Government Budget Statement II 2007/08, p. 57, Table 3.2

²³ Eastern Cape Department of Health Annual Report, 2006/07, p. 269

However, including the equitable share allocation of R65.94 million²⁴, the Department's overall budget allocation towards the HIV/AIDS sub-programme increased by five % in real terms, from R271.07 million in 2006/07 to R299.14 million in 2007/08 (see Diagram 1).

Diagram 1: HIV and AIDS Programmes Budget Allocations²⁵



It seems highly unlikely that the Department will be able to fund a 48 % increase in those receiving ARVs by March 2008 (from 27 000 by end 2006/07 to 40 000 by end 2007/08) when its budget is set to increase by only 5 % over the same period. Critically, this budget increase also raises questions about the Eastern Cape Health Department's ability to contribute effectively towards the nationally planned provision of treatment, care and support services to 80% of people living with HIV and their families by 2011, as outlined in the NSP.²⁶

The Comprehensive HIV and AIDS conditional grant of R233.20 million is divided amongst the various HIV Programmes of the province, with R142.81 million being dedicated towards the ART Programme component. R38.76 million of this is allocated towards the compensation of employees, R103.68 million to goods and services and R360 000 to the payment of capital assets.²⁷ These allocations are divided equally between the twelve months of the financial year according to the HIV/AIDS Business Plan of the Province.

Comprehensive HIV & AIDS Conditional Grant 2007/08 Business Plan Rejected:

For the First Quarter of the 2007/08 financial year ending on the 30th of June 2007, no funds had been transferred from the National Department of Health to the Eastern Cape Department of Health for the Comprehensive HIV and Aids Grant.²⁸ An amount of R58.299 million was supposed to have been transferred to the Eastern Cape during the

²⁴ Eastern Cape Provincial Government Budget Statement II 2007/08, p. 65

²⁵ These figures are the HIV/AIDS sub-programme allocations under Programme 2: District Health, Eastern Cape Provincial Government Budget Statement II 2007/08, p. 65

²⁶ HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP), p. 59

²⁷ HIV/AIDS/STI's 2007-2008 Business Plan, Eastern Cape Department of Health, p.28-29

²⁸ National Treasury 4th Quarter Spending Results, 2006/07. Taken from Conditional Grants transferred from National Department and Actual Payments made by provinces, 4th Quarter ended 31 March 2007, Eastern Cape Province.

First Quarter of the financial year,²⁹ but was withheld as there were problems with the Eastern Cape Department of Health's HIV and AIDS Business Plan.³⁰ Each provincial Department of Health is required by law to produce such plans, which should clearly articulate how the Department intends to spend its conditional grant allocation.³¹ National Treasury is prohibited from releasing funds ring-fenced for HIV/AIDS programmes unless the National Department of Health has certified to the National Treasury that provincial business plans have been approved before the start of the financial year.³²

The provincial Department of Health was late in submitting this Business Plan. The National Department of Health was expected to approve and submit all provincial business plans to National Treasury by the 13th of April 2007, while the Eastern Cape Department of Health only submitted its Business Plan to the National Health Department on the 18th of that month.³³

The Eastern Cape Department of Health HIV and AIDS Business Plan was not approved due to two main factors as explained in a letter dated 20 April 2007 from the National Director-General of Health, Mr Thami Mseleku, to the Head of the Eastern Cape Department of Health, Mr Lawrance Boya:³⁴

1. Costed activities in this plan amount to R285.318 million which is over the DoRA allocation of R233.204 million for the Eastern Cape Province for the 2007/08 financial year. Planned activities that exceed National Treasury allocation is a deviation from DoRA and cannot be accepted.

²⁹ Ibid.

³⁰ Letter from Director-General of the National Department of Health, Mr T. Mseleku, to the Eastern Cape Health Superintendent, Mr L. Boya. Re: Comprehensive HIV and AIDS Conditional Grant Business Plan for the Financial Year 2007/08. 20 April 2007.

³¹ As outlined in Section 10(1) of the Division of Revenue Act, Act 1 of 2007, which appeared in Government Gazette 29763 dated 31 March 2007. The Division of Revenue Act is tabled annually and serves to "provide for the equitable division of revenue raised nationally among the national, provincial and local spheres of government for the financial year and the responsibilities of all three spheres pursuant to such division." This Act also outlines all other allocations to provinces, local government and municipalities from the national government and details the conditions on which these allocations are made.

³² Ibid

³³ Letter from Director-General of the National Department of Health, Mr T. Mseleku, to the Eastern Cape Health Superintendent, Mr L. Boya. Re: Comprehensive HIV and AIDS Conditional Grant Business Plan for the Financial Year 2007/08. 20 April 2007.

³⁴ Letter from Director-General of the National Department of Health, Mr T. Mseleku, to the Eastern Cape Health Superintendent, Mr L. Boya. Re: Comprehensive HIV and AIDS Conditional Grant Business Plan for the Financial Year 2007/08. 20 April 2007. According to the Division of Revenue Act 2007, section 25 (1), a transferring national officer may withhold the transfer of a Schedule 4, 5, 6 or 7 allocation or any portion of such an allocation for a period not exceeding 30 days, if—

- (a) the province or municipality does not comply with the provision of the Act or conditions to which the allocation...is subject;

Division of Revenue Act 2007, Government Gazette, 31 March 2007, p. 30

2. The timeframes on the business plan refer to the previous financial year (eg. the start and end dates of all activities in all programmes refers to the 2006/07 financial year).³⁵

The National Department of Health thus requested that these errors be corrected in the business plan and be resubmitted for approval and subsequent referral to National Treasury.³⁶ The National Department of Health received a revised business plan from the Eastern Cape on 5 June 2007.³⁷

Section 25 (3) of DoRA 2007 stipulates that:

a transferring national must, seven working days or such shorter period as may be approved by the National Treasury prior to withholding an allocation in terms of subsection (1)–

- (a) give the relevant receiving officer—
 - (ii) an opportunity to submit written representations, within seven days as to why the allocation should not be withheld;³⁸

There is no doubt that this conditional grant is vital to the province given the high prevalence rate and levels of poverty in the Eastern Cape, and thus it would be expected that the Eastern Cape would have used the seven-day window of opportunity to submit reasons as to why the grant should not be withheld. Should this not have been the case, the Eastern Cape Department of Health must be held accountable for not attempting to have the conditional grant transferred.

On the 27th of June 2007, a letter of approval affirming that the key issues had been addressed in the redrafting of the business plan was sent to the Eastern Cape Department of Health from the National Department stating that “all withheld funds due to your Province will be added to your next payment schedule”.³⁹ Consequently, the first transfer of R77.732 million of the HIV and AIDS Conditional Grant was received by the

³⁵ It was noted in this letter that “While the National Department of Health acknowledges that the heading dates on template, especially table 4 of the indicators, could not be changed because of the password, the rest of the business plan should not be affected by this”. Letter from Director-General of the National Department of Health, Mr T. Mseleku, to the Eastern Cape Health Superintendent, Mr L. Boya. Re: Comprehensive HIV and AIDS Conditional Grant Business Plan for the Financial Year 2007/08. 20 April 2007.

³⁶ Section 25 (5) of DoRA states that:

- (a) The National Treasury may when a transferring national officer is withholding an allocation in terms of subsection (1) instruct or approve a request from that transferring national officer to withhold an allocation for a period longer than 30 days, but not exceeding 120 days, if the withholding will—

facilitate compliance with this Act or the conditions to which the allocation is subject; Division of Revenue Act 2007, Government Gazette, 31 March 2007, p. 30

³⁷ Letter from Dr N. Xundu, Cluster Manager: HIV & AIDS and STI's. Re: Transfer of the Comprehensive HIV and AIDS Conditional Grant to Eastern Cape. 18 October 2007.

³⁸ Division of Revenue Act 2007, Government Gazette, 31 March 2007, p. 30

³⁹ Letter from Director-General of the National Department of Health, Mr T. Mseleku, to the Eastern Cape Health Superintendent, Mr L. Boya. Re: Comprehensive HIV and AIDS Conditional Grant Business Plan Approval for the Financial Year 2007/08. 27 June 2007.

provincial Health Department on the 20th of July 2007, close to four months into the financial year.⁴⁰

However, despite the fact that no funds had been transferred to it up until this point, the Department had already spent R54.19 million on the Comprehensive HIV and AIDS programme by the end of the First Quarter as at the 30th of June 2007.⁴¹ The PSAM was advised that this money was taken from the provincial equitable share, when in fact it should have been drawn from the Comprehensive HIV and Aids Conditional Grant.⁴² This is of concern, given the fact that the equitable share funds that were utilised should have been planned for and used by other health programmes, and it can thus be assumed that a trade-off amongst other healthcare services had to take place in order to compensate for the Eastern Cape Department of Health's failure to submit a satisfactory business plan which resulted in the conditional grant not being transferred timeously.

It is important to note that the Department was allocated R65.94 million from the equitable share for 2007/08 for the HIV/AIDS Programme⁴³. However, the Department is not reporting that the spent funds have been drawn from this allocation. The Eastern Cape Director of HIV and AIDS and STIs, Ms Coceka Nogoduka, stated that in order to reimburse the equitable share funds utilised for the HIV and AIDS Programme, "interface needs to be affected" and that this process had already taken place for the ARVs as these drugs were procured from the equitable share. It was also noted that there were outstanding payments that needed to be made to the National Health Laboratory Services. Furthermore, it was stated that "expenditure of funds from the equitable share will be journalised".⁴⁴ Up until 21 October 2007, the Department has not indicated that this expenditure has in fact been budgeted for in terms of the equitable share allocation for HIV/AIDS.

Essentially, regardless of the reason why this funding was withheld, it could have been avoided and most certainly should not be allowed to occur in the future. Both the National and Provincial Department of Health need to ensure that all steps are taken to overcome the provincial Department's history of poor planning in order to ensure that it receives the necessary funds to implement its HIV and AIDS programmes in the upcoming financial years.

⁴⁰ Letter from Eastern Cape Department of Health Director for HIV & AIDS and STIs, Ms C. Nogoduka. Re: Response to the Public Service Accountability Monitor on explanations regarding the Comprehensive HIV and AIDS Conditional Grant Business Plan. Dated 9 September 2007, but only sent via facsimile to the PSAM on 11 October 2007.

⁴¹ National Treasury 4th Quarter Spending Results, 2006/07. Taken from Conditional Grants transferred from National Department and Actual Payments made by provinces, 4th Quarter ended 31 March 2007, Eastern Cape Province.

⁴² Letter from Eastern Cape Department of Health Director for HIV & AIDS and STIs, Ms C. Nogoduka. Re: Response to the Public Service Accountability Monitor on explanations regarding the Comprehensive HIV and AIDS Conditional Grant Business Plan. Dated 9 September 2007, but only sent via facsimile to the PSAM on 11 October 2007.

⁴³ Eastern Cape Provincial Government Budget Statement II 2007/08, p. 65

⁴⁴ Letter from Eastern Cape Department of Health Director for HIV & AIDS and STIs, Ms C. Nogoduka. Re: Response to the Public Service Accountability Monitor on explanations regarding the Comprehensive HIV and AIDS Conditional Grant Business Plan. Dated 9 September 2007, but only sent via facsimile to the PSAM on 11 October 2007.

Given the fact that this conditional grant has been transferred to the Department late into the financial year, and that the Department had only spent 23.22% of this grant by the end of August 2007, it is likely that the Department will under spend on this conditional grant.⁴⁵ Since all unspent conditional grant allocations revert to the National Revenue Fund unless it can be proven that the unspent allocation is committed to identifiable projects, the Eastern Cape Department of Health needs to ensure that all potentially unspent funds from this allocation remain dedicated to the implementation of this programme by motivating for these funds to be retained as rollover funds for 2008/09.⁴⁶

The Department also needs to ensure that its financial reporting is kept up to date and accurate regarding this conditional grant so that it can justify its spending and apply for increased funding and the rollover of funds. This is especially important in the context of the Eastern Cape Department of Health's record of weak financial management, with nine audit disclaimers and one adverse opinion from the Auditor-General in eleven years, and a poor track record regarding the expenditure of this conditional grant. The Department's spending of this conditional grant has also been erratic, with under expenditure between 2000/01 and 2003/04⁴⁷ and overspending in 2005/06 and 2006/07.⁴⁸

The crucial point is that the Eastern Cape Department of Health's HIV and AIDS and STI's 2007/08 Business Plan is based on the assumption that the Department will receive an allocation of R233.204 million in the form of the conditional grant during the financial year. This Business Plan is made up of costed activities that can only be effectively implemented if the full allocation is received, failing which planned activities and objectives will be negatively affected and targets will in all likelihood not be reached. It is thus necessary that the Department reflect on the situation and ensure that the late transfer of this crucial conditional grant is avoided in the future by addressing the factors that led to this occurring in the first place. This may include disciplinary action being taken against those responsible for the current state of affairs.

⁴⁵ Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. August 2007.

⁴⁶ Section 28 of DoRA states the following:

28.

(1) Despite the provisions of the Public Finance Management Act or the Municipal Finance Management Act relating to roll-over, any conditional allocation...that is not spent at the end of a financial year reverts to the National Revenue Fund, unless the relevant receiving officer can prove to the satisfaction of the National Treasury that the unspent allocation is committed to identifiable projects.

(2) Despite subsection (1), the National Treasury may at the request of a transferring national officer, provincial treasury or municipality approve—

(a) roll-overs from a conditional grant allocation to the next financial year
Division of Revenue Act 2007, Government Gazette, 31 March 2007, p.32

⁴⁷ Allan, C., Overy, N., Somhlaba, Z., Tetyana, V. and Zepe, L. 2004. The Crisis of Public Health Care in the Eastern Cape: The post-apartheid challenges of oversight and accountability.

Grahamstown: Public Service Accountability Monitor, p. 125

⁴⁸ In 2006/07 the Comprehensive HIV and AIDS conditional grant was overspent by R45.94 million, totaling expenditure at R277.96 million over the R232.02 million received. Eastern Cape Department of Health Annual Report, 2005/06, p.33. Eastern Cape Department of Health Annual Report, 2006/07, p. 36

The National Department of Health also needs to be held to account if it failed to assist the Eastern Cape in drawing up these plans and ensuring that these were up to standard. As Dr Nomonde Xundu, the National Department of Health's Cluster Manager for HIV/AIDS and STI's stated, "The National Department of Health has a responsibility to support provinces on programme implementation...The [National] Department further assists provinces in preparing draft business plans for each financial year."⁴⁹ This begs the question as to why the National Department did not assist the Eastern Cape Department and identify the shortcomings of the Eastern Cape's business plan before it was submitted.

Financial Reporting:

The state of the Eastern Cape Department of Health's monthly HIV and AIDS conditional grant financial reports up until the end of August 2007 are problematic in that the Chief Financial Officer's signature is missing on most documents and there is no compliance summary despite funds not having been received.⁵⁰

Over and above this, there appear to be inconsistencies between the monthly financial reports and the HIV/AIDS Business Plan. For example, the allocation for the ART sub-programme is R142.81 million according to the business plan, whereas in all of the 2007/08 monthly financial reports up until August 2007 it is stated that R168.77 million is scheduled for transfer to this sub-programme. According to the HIV/AIDS Business Plan, the Department should be spending R11.9 million for the ART Programme per month every month of the financial year. According to the financial reports, the Department spent R8.87 million in April, R30.71 million in May, R16.56 million in June, R9.92 million in July and R11.30 million in August.⁵¹ The National Department has been transferring R11.90 million per month for ARVs (as outlined in the Business Plan) since its first transferal in July.⁵²

According to the June 2007 financial report, the Department had up until this point spent R57.08 million on the HIV and AIDS Programme.⁵³ This is R2.89 million higher than the expenditure reported in the 2007/08 Fourth Quarter figures released by National Treasury.⁵⁴

However, regardless of what the correct expenditure figures are according to the monthly reports, the Department reported to have spent a total of R54.15 million on the

⁴⁹ Letter from Dr N. Xundu, Cluster Manager: HIV & AIDS and STI's. Re: Transfer of the Comprehensive HIV and AIDS Conditional Grant to Eastern Cape. 18 October 2007.

⁵⁰ It would appear that some of the calculations are inaccurate. The Eastern Cape Department of Health is required to submit monthly expenditure reports on the 15th of every month on a standardised reporting template. Letter from Director-General of the National Department of Health, Mr T. Mseleku, to the Eastern Cape Health Superintendent, Mr L. Boya. Re: Comprehensive HIV and AIDS Conditional Grant Business Plan Approval for the Financial Year 2007/08. 27 June 2007.

⁵¹ Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. April 2007 – August 2007.

⁵² Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. July 2007 and August 2007.

⁵³ Ibid, June 2007.

⁵⁴ National Treasury 4th Quarter Spending Results, 2006/07. Taken from Conditional Grants transferred from National Department and Actual Payments made by provinces, 4th Quarter ended 31 March 2007, Eastern Cape Province.

HIV and AIDS Programme by the end of August 2007.⁵⁵ The Department has thus spent only 23.22% of the conditional grant funds available for 2007/08 during the first five months of the financial year on the HIV and AIDS Programme in the Eastern Cape.⁵⁶ If one examines the August 2007 financial report, in terms of the ARV sub-programme expenditure, the expenditure amounts to only 30.09 % of the entire budget despite it being almost mid-year on the financial calendar.⁵⁷

There also appears to be some discrepancy between the Department's reported June and July total expenditure figures. In June, the Department had, according to the monthly report spent R57.08 million but then the total expenditure as at the end of July is reported to be R51.22 million, despite having received an additional R19.43 million in that month.⁵⁸ In terms of funds received, the reports indicate that for the month of July⁵⁹ the Department received a total of R19.43 million and the same amount for August 2007. It appears that this should be a total of R38.86 million up until the end of August 2007, whereas the Department reports to have received R77.73 million in total in both the reports for July and August 2007.⁶⁰ While this figure correlates with the amount the Eastern Cape HIV and AIDS and STI's Director reported was transferred on the 20th of July 2007,⁶¹ the way in which it is being set out in the monthly financial reports is inconsistent.

A case study: Midland Hospital, Graaff-Reinet

This research report will highlight some of the issues that arose directly as a result of the late transferal of funds. However, it will also focus on the structural challenges faced in rolling out ARVs at this site.

Midland Hospital in Graaff-Reinet, which serves a population of approximately 66 700 people, was accredited as an ART site on 19 March 2007.⁶² According to the latest available data, the HIV prevalence rate in the Cacadu District, in which Graaff-

⁵⁵ Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. August 2007. This is not all conditional grant funds though, as the Department had already reportedly spent R57.08 million by the end of June. Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. June 2007 and August 2007.

⁵⁶ Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. August 2007.

⁵⁷ Ibid, August 2007

⁵⁸ This mistake is then again repeated for the month of August. This pattern is repeated for all the sub-programmes that make up the HIV and Aids Programme. Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. June 2007 – July 2007.

⁵⁹ The first month conditional grant funds were transferred to the Eastern Cape Department of Health.

⁶⁰ Conditional Grants to Provinces, Monthly Report by Receiving Provincial Departments, Eastern Cape Province, National HIV and AIDS Conditional Grant. July 2007 and August 2007

⁶¹ Letter from Eastern Cape Department of Health Director for HIV & AIDS and STIs, Ms C. Nogoduka. Re: Response to the Public Service Accountability Monitor on explanations regarding the Comprehensive HIV and AIDS Conditional Grant Business Plan. Dated 9 September 2007, but only sent via facsimile to the PSAM on 11 October 2007.

⁶² Comprehensive HIV and AID Facility Accreditation Form, Midland Hospital, Graaff-Reinet, p.1

Reinet is situated, is 22.8 %.⁶³ The Midland Hospital ART site is intended to serve the treatment needs of people living in Graaff-Reinet itself, Aberdeen, Willowmore, Klipplaat, Steytlerville, Jansenville and Nieu-Bethesda. Willowmore, at 11 500, makes up the largest population in the catchment area (other than Graaff-Reinet), and is situated 170 km from the ARV site. There are 13 clinics and health centers which refer patients to the Midland Hospital ARV clinic (also known as iThemba Clinic) once they have undergone Voluntary Counselling and Testing (VCT) and have been placed on the readiness programme at the feeder clinics, where they commence treatment.⁶⁴

iThemba Clinic aims to have 130 patients on treatment during the first year in operation. As of the end of August 2007, there were a total of 61⁶⁵ patients who had been placed on treatment at the clinic. By the end of August, there were 30 patients who were being prepared for treatment on the Readiness programme at the site. By this stage, there were 37 patients from Graaff-Reinet on treatment and 23 patients from the surrounding areas that fall under Midland Hospital's catchment area.⁶⁶

Table 2 below shows the number of patients on treatment from each of the feeder clinics for the first 6 months of iThemba Clinic's ARV programme.⁶⁷

Table 2: Patients on Treatment at iThemba Clinic

Primary Health Care Facilities (Feeder Clinics)	Town	Distance from Graaff-Reinet	March	April	May	June	July	August	Subtotal
Umasizakhe	Graaff-Reinet	< 5km	0	1	1	2	5	2	11
Kroonvale	Graaff-Reinet	< 5km	0	0	2	1	0	1	4
Day Hospital	Graaff-Reinet	< 5km	0	1	5	3	4	5	18
Horseshoe	Graaff-Reinet	< 5km	0	0	3	2	1	0	6
Unionstreet Cacadu	Somerset East	123 km	0	0	0	1	0	0	1
Nieu-Bethesda	Nieu-Bethesda	50km	0	0	0	0	0	0	0
Wongalethu	Klipplaat	135 km	0	0	0	0	0	0	0
Baviaans	Steytlerville	186 km	0	0	2	1	0	1	4
Rietbron	Rietbron	199 km	0	0	0	0	0	0	0
Willowmore	Willowmore	170 km	2	0	1	1	1	2	7
Masakane	Aberdeen	56 km	0	0	0	2	1	2	5

⁶³ National HIV and Syphilis Prevalence Survey South Africa 2006, Department of Health 2007, p. 22

⁶⁴ Comprehensive HIV and AID Facility Accreditation Form, Midland Hospital, Graaff-Reinet, p. 1

⁶⁵ This figure differs between the various August 2007 reports. In the table compiled by the ARV Coordinator which indicates how many patients from each feeder clinic are on treatment, the total number of patients is 61. In the Monthly Tasks Summary Form for the same month it is stated that 60 patients are on treatment already, whereas in the August 2007 Monthly Report, it is stated that 61 patients have been approved by the Review Board and that only 56 patients are already on treatment. iThemba Clinic Midland Hospital Patients on Treatment, August 2007, Compiled by ARV Co-ordinator. iThemba Clinic Monthly Tasks Summary Form, August 2007, Compiled by ARV Co-ordinator. Monthly Report, August 2007, Compiled by ARV Co-ordinator.

⁶⁶ iThemba Clinic Monthly Tasks Summary Form, August 2007, Compiled by ARV Co-ordinator.

⁶⁷ iThemba Clinic, Midland Hospital, Patients on Treatment up until end of August 2007, Compiled by ARV Coordinator

Kwazamkucinga	Jansenville	84 km	0	0	0	0	3	0	3
Brugstreet	Jansenville	84 km	0	0	1	1	0	0	2
			2	2	15	14	15	13	61

iThemba Clinic asserts that it has no waiting list for patients in need of treatment.⁶⁸ However, this is not an accurate reflection of the need in the area,⁶⁹ but instead illustrates the bottlenecks at the Primary Health Care (PHC) facility level where there are delays in getting patients tested for HIV and testing HIV positive patients in order to determine whether they need ARVs by assessing their CD4 count and viral load.⁷⁰

For example, the Voluntary Counselling and Testing (VCT) nurse at Willowmore Clinic, who had been employed in the post for two months at the time of the interview, could not give an exact figure of the number of patients who needed treatment from that clinic. She estimated that “less than 30” patients who attended the clinic were HIV positive.⁷¹ No clarity could be given as to how many of these should be referred to iThemba Clinic as the nurse had not completed their CD4 count and viral load tests and could thus not determine whether they needed treatment or not.⁷² Consequently the number of patients being referred to the ARV clinic is exceedingly low and does not necessarily reflect the need in the area.

The nurse at the Baviaans Clinic in Steytlerville could also not provide clarity on the number of HIV positive patients at that clinic. It was estimated to be “more or less 50”. No exact figure could be given as to how many of these patients needed treatment either: “I’m also not sure how many of those need treatment or have a CD4 count less than 200. With me there are 1...2...about 5 cases. Because at the moment I have about 13 positive patients ...yes, let’s say about 5 need treatment. I think that on their side (the other nurses) there have been a few cases of people with low CD 4 counts that have been followed through the programme”.⁷³

The problems in identifying patients who are eligible for treatment at the feeder clinic level explains why it is that iThemba Clinic would have no waiting list as such. The number of people who are not coming forward to be tested also needs to be taken into account, as well as the number of patients who are being turned away at feeder clinic level. As the Camdeboo LSA HIV/AIDS/STI Programme Manager stated, “The problem is that our statistics are not showing a true reflection of what the demand is out there.

⁶⁸ Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007

⁶⁹ At the Primary Health Care Level, patients are reportedly being turned away at clinics due to the high staff-patient ratios at these clinics. Interview HIV & AIDS & STI Programme Manager for the Camdeboo LSA, Graaff- Reinet, 30 August 2007.

⁷⁰ The National Guidelines state that HIV positive patients with a CD4 count of less than 200 or those showing symptoms of Stage 4 infection are entitled to and should commence ARV treatment. National Antiretroviral Treatment Guidelines, National Department of Health, South Africa, 2004 and Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach, 2006 Revision, World Health Organisation. Both available at www.doh.gov/docs/arv-f.html

⁷¹ Interview with VCT Professional Nurse at Willowmore Clinic, Willowmore, 10 August 2007.

⁷² Ibid.

⁷³ Interview with Professional Nurse at Baviaans Clinic, Steytlerville, 10 August 2007.

We are only showing what our clinic facility is seeing. We are not showing what we are turning away on a daily basis because there are some restrictions in some clinics.”⁷⁴

Over and above these issues, the key challenges that are hindering the Midland Hospital ARV Clinic’s ability to implement its programme are the fact that the site’s conditional grant funding was only transferred five months into the financial year, human resource constraints and transport problems.

Late Budget Transfer:

No conditional grant funds were transferred to the ARV site at the Midland Hospital in Graaff-Reinet for the first five months of the financial year, with the first allocation only being transferred on 5 September 2007.⁷⁵ No explanation was provided to the Clinic as to why funds had only been transferred on this date, despite the conditional grant having been transferred to the provincial department in late July.

The amount eventually transferred to the ARV Clinic on 5 September 2007 was, however, not sufficient to cover the costs already incurred by the Hospital in supporting it (due to the conditional grant funds not having been transferred timeously). Initially, funds from the Hospital’s equitable share budget had been used to cover the costs of the Clinic in the hope that once the ARV conditional grant budget had been loaded, the necessary funds would be redistributed into the Hospital’s budget. The CEO of the Hospital despaired that the amount transferred was hopelessly too little.⁷⁶

The ARV Clinic was utilising funds from the Hospital to cover the costs of the ARV Clinic staff establishment salaries, transport and providing meals to patients from the surrounding towns who spent the day at the clinic while being assessed or collecting treatment supplies.⁷⁷

While the Hospital was funding all the financial needs of the ARV Clinic, it had been decided that compromises would have to be made and that once the ARV Clinic’s budget had been loaded, it would help pay for some of the Hospital’s needs.⁷⁸

In addition, the reasons for these funds being withheld, and when they should be expected, was never communicated to the ARV Clinic by the provincial Department. Health officials in Bhisho announced that the budget would be loaded ‘the following day’ on a few occasions, which never occurred.⁷⁹ Despite this, the ARV Clinic was still under pressure to meet its targets in terms of ARV treatment.

The fact that the ARV Clinic had no access to budgeted conditional grant funds placed heavy constraints on the site. The lack of funding meant that posts could not be filled at the ARV Clinic, transport problems could not be alleviated by hiring private transport, nurses could not be trained in order to facilitate the back-referral of patients, and other hospital programmes had to suffer as a consequence of the Hospital covering the costs

⁷⁴ Interview HIV & AIDS & STI Programme Manager for the Camdeboo LSA, Graaff- Reinet, 30 August 2007.

⁷⁵ Letter from Midland Hospital CEO, 20 September 2007

⁷⁶ Telephonic Correspondence with Midland Hospital CEO, 20 September 2007

⁷⁷ Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007

⁷⁸ Ibid

⁷⁹ Midland Hospital Graaff-Reinet ARV Stakeholders Meeting, 29 August 2007

of the ARV Clinic. As the Midland Hospital CEO stated, “if those funds were transferred on time we would have been able to train nurses up, we could have back-referred, our transport issues would have been sorted out. That is where at this stage we are being blocked. It places extreme stress on people. It is impossible for me to back-refer patients to a clinic where there is only one person who hasn’t even received training. That would be as good as killing our own people, because they have no support”.⁸⁰

One of the greatest challenges forced upon the Midland ARV Clinic due to the funding not being transferred timeously was that there was no budget available for nurses to be trained at the feeder-clinic level.⁸¹ This resulted in patients not being able to be back-referred to their local clinics once they were on the programme, and this blocked additional people from accessing treatment.

Given the insufficient amount that has been transferred to the ARV Clinic to date, it is of concern that the trade-off, according to the Hospital CEO, should the situation not be rectified, will be that the Hospital will have to buy less medical equipment in order to cover the costs of funding the ARV Clinic. What will remain to be seen is if the ARV Clinic receives the full amount it requested before the financial year and whether or not these remaining funds will be transferred timeously in order for the above-mentioned constraints to be dealt with.

The provincial Department of Health must account for its failure to ensure the timeous receipt of conditional grant funding. It must also account for disciplinary steps, if any, taken against officials who failed to ensure the timeous receipt of such funds. The Department must also explain what measures have been put in place to ensure that this state of affairs does not re-occur in the future.

Human Resources:

The issue of Human Resources is crucial in the context of the impact that HIV and AIDS has had on the health system in South Africa. As stated in the NSP, “HIV and AIDS affect both the supply and demand of health care systems.”⁸² While the effect of the demand it places on the healthcare system is more obvious, “on the ‘supply’ side of health systems, the human resource effect of HIV are two-fold: the stress and morale impacts of rapidly changing epidemiological, demand and mortality profiles in patients caused by HIV and AIDS, and HIV infection in providers themselves.”⁸³

This is an issue that requires attention. As the Camdeboo LSA HIV/AIDS Manager states, “You cannot open an ARV site before you have the human bodies there... we’ve actually been warned by other accredited sites: ‘see that your resources are in place before you start offering it (ARVs) out to the communities’”.

According to the 2007/08 HIV/AIDS and STI Business Plan for the Eastern Cape Department of Health, each accredited ART facility should be made up of the following staffing component along with the stated salary level:⁸⁴

⁸⁰ Ibid

⁸¹ Interview HIV & AIDS & STI Programme Manager for the Camdeboo LSA, Graaff- Reinet, 30 August 2007.

⁸² HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP), p. 44

⁸³ Ibid.

⁸⁴ HIV & AIDS & STI’s 2007-2008 Business Plan, Eastern Cape Department of Health, p 25.

Table 3: Midland Hospital ARV Clinic Human Resource Complement

Post Required by Accredited ARV Site⁸⁵	Status of Post at Midland Hospital ARV Clinic⁸⁶	Source of Funding as outlined in Business Plan⁸⁷	Source of funding at Midlands Hospital ARV Clinic⁸⁸	Prescribed Salary Level⁸⁹
Assistant Director	Filled	Conditional Grant	Conditional Grant	Level 9
Chief Professional Nurse	Filled	Conditional Grant	Conditional Grant	Level 8
Senior Professional Nurse	Available to and established at the ARV Clinic, but on the Hospital staff establishment	Conditional Grant	Equitable Share ⁹⁰	Level 7
Data Capturer	Filled	Conditional Grant	Conditional Grant	Level 4
Administrative Officer	Vacant		N/A	Level 7
Social Workers ⁹¹	2 available to and established at the ARV Clinic, but on the Hospital staff establishment	Conditional Grant	Equitable Share	Level 8
Dietician	Available to and established at the ARV Clinic, but on the Hospital staff establishment	Conditional Grant	Equitable Share	Level 8
Doctor	Part-time	Conditional Grant	Conditional Grant	Level 11 ⁹²
Pharmacist	Available to and	Conditional	Equitable Share	Level 9

⁸⁵ Ibid.

⁸⁶ This information is based on Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007

⁸⁷ HIV & AIDS & STI's 2007-2008 Business Plan, Eastern Cape Department of Health, p 25.

⁸⁸ This information is based on Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007

⁸⁹ HIV & AIDS & STI's 2007-2008 Business Plan, Eastern Cape Department of Health, p 25.

⁹⁰ This post is being funded by the Midland Hospital Equitable Share for the compensation of employees. This is the case for all the posts that are stated as being funded by the Equitable Share.

⁹¹ The Eastern Cape Department of Health's HIV AIDS and STI Business Plan for 2007/08 does not specify how many social workers are needed at each ARV site. HIV & AIDS & STI's 2007-2008 Business Plan, Eastern Cape Department of Health, p 25.

⁹² This post's salary is set at Level 10 at the Midland ARV Clinic.

	established at the ARV Clinic, but on the Hospital staff establishment ⁹³	Grant		
Pharmacist Assistant	Available to and established at the ARV Clinic, but on the Hospital staff establishment	Conditional Grant	Equitable Share	Level 6

According to the Eastern Cape HIV/AIDS/STI 2007/08 Business Plan, this staffing component should be fully funded by the Comprehensive HIV/Aids Conditional Grant.⁹⁴

As Table 3 shows, the staffing complement of the iThemba Clinic fulfils some of these components, but is lacking in others. The posts which are filled and on the ARV Clinic's staff establishment at present are the positions of Assistant Director, Chief Professional Nurse and Data Capturer. The position of Senior Professional Nurse is filled but this position lies on the Midland Hospital Staff establishment, and is thus not being funded by the Comprehensive HIV and AIDS Conditional Grant. This blocks a senior post in the hospital staff component from being filled, and places constraints on the hospital's capacity.⁹⁵ The post of administrative officer is vacant, which, according to the CEO of Midland Hospital, "is not much of a crisis because the data capturer can actually do both the jobs".⁹⁶ There are also two social workers who are available to the ARV clinic but are also on the hospital staff establishment. In the opinion of the CEO, having two social workers is not enough, given the need in this area.

There is no full-time doctor on the iThemba Clinic staff establishment. The post is however being temporarily filled by a doctor who is assisting on a six-month contract, but who cannot be employed full-time as he is too old. This doctor is being paid a Level 10 salary, as apposed to the Level 11 salary outlined in the HIV/AIDS Business Plan of the Eastern Cape. The post has been advertised twice, at a level 10 salary. No explanation for the variance between the salary level as outlined in the Business Plan and the Midland ARV Clinic post has been provided. According to Midland Hospital CEO, the low level of salary is what is hindering the post from being filled. "We can't find a suitable person who will do the work for that salary. No one will come at that level, it is too low. They just won't. We have advertised and no one even applies."⁹⁷

Originally there were two pharmacists available to the ARV clinic, but one has resigned since accreditation. This is proving to be highly problematic given the need in the area. However, the appointment of pharmacists is another constraining factor. Before a qualified pharmacist was appointed, the LSA Pharmaceutical Services Manager was

⁹³ Pharmacists who dispense only ARV medication are only appointed in larger hospital complexes and not at Hospitals the size of Midlands. Interview with LSA Pharmaceutical Services Manger, Graaff-Reinet, 30 August 2007.

⁹⁴ HIV & AIDS & STI's 2007-2008 Business Plan, Eastern Cape Department of Health. p 25.

⁹⁵ Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007

⁹⁶ Ibid.

⁹⁷ Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007.

involved in actively recruiting for 18 months. The post was advertised locally, provincially, nationally, internationally and in the NGO sector, and yet they struggled for a year and a half to appoint a suitable candidate.⁹⁸

According to the LSA Pharmaceutical Services Manger, the biggest challenges in this regard is that the salaries offered by the provincial health department are not competitive with those in the private sector and that there are not enough incentives for pharmacists to relocate to this area.⁹⁹ This post is again vacant due to this particular staff member having resigned recently. According to the CEO of Midland Hospital, the site should already have been accredited in August of 2006, but the process was delayed due to only one pharmacist being available. "We realised that there would be no way that we would cope with only one pharmacist."¹⁰⁰ The fact that the Hospital is now back in this position is very troubling given the demands placed on the one pharmacist who has to not only dispense ARVs, but must also dispense all specialised medication for patients who have been back-referred from Port Elizabeth and the area's psychiatry medication.

The staffing problems are not only affecting the ARV Clinic's capacity to put as many people as possible on treatment, but, at the feeder clinic level, a shortage of personnel and the capacity constraints of the existing staff cause problems relating to identifying and preparing patients to be referred to the Midland ARV Clinic and back-referring patients to the feeder clinics to continue their treatment, thus opening up additional space for more patients to be initiated onto the programme at the ARV clinic. The ARV Clinic reported that "at clinic level there is a big need for more staff [as there is] only one sister per clinic to do clinic, chronic, antenatal, amongst others. Clinics need a dedicated sister to do VCT and prepare the patients on ARV. At the moment the patients are not prepared for ARV at clinic level because of the human resource problems."¹⁰¹

The Midland Hospital CEO argues that the problem with the ARV rollout in the area lies with the clinics. "They can't cope. They do not have enough hands to do all the work."¹⁰² The greatest bottleneck in the programme is that there is a shortage of nurses at most, if not all the feeder clinics. This means that nurses are often alone in the clinic and have to see to all the health issues of the patients, and thus do not have enough time to dedicate to testing patients for HIV and doing all the follow-up procedures such as viral-load and CD4 count tests, as well as the other aspects of the readiness programme, before patients are referred to Midland Clinic.

The ARV Clinic's Assistant Director characterised the issue as being that "the problem is that there is only one nurse at the clinic and she must do everything." While nurses run the operations of entire clinics, they are not able to adequately prepare HIV positive patients to be referred to the hospital to commence treatment.¹⁰³

For example, a nurse working at the Baviaans Clinic stated that "often one is the only nurse on duty so you actually have to do everything alone. In my opinion if we could

⁹⁸ Interview with LSA Pharmaceutical Services Manger, Graaff-Reinet, 30 August 2007.

⁹⁹ Ibid.

¹⁰⁰ Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007.

¹⁰¹ iThemba Clinic, Midland Hospital, Monthly Report, August 2007, Compiled by ARV Co-ordinator.

¹⁰² Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007

¹⁰³ Interview with ARV Clinic's Assistant Director, Graaff-Reinet, 28 August 2007.

each get an assistant nurse that would be great... You are moving one thing to the next, so I definitely think that we each need an assistant nurse.”¹⁰⁴

This staff shortage resulted in patients arriving at the ARV Clinic having not been adequately prepared to commence ART. The Assistant ARV Director stressed that “they put pressure on us to place the patients on treatment when they arrive here but the thing is that the patient doesn’t even have a clue when they arrive at the ARV clinic what taking ARVs is actually about. Things like the fact that they will have to be taking this medication for life and issues such as tablet counting. These things can’t be done at the clinic level because there is only one nurse in most of those places, so we have to do it. So we still have to work with the patients when they arrive. But we also work according to the guidelines and we don’t make them wait longer than they have to.”¹⁰⁵

Another issue that fuels this problem is that the nurses at the clinics have not received adequate training on the ARV programme since Midland was accredited in March 2007. This was partly due to the fact that the budget, which includes an allocation for this training, was not transferred timeously, but training is further compromised due to the staffing shortages at the feeder clinics: nurses cannot leave the clinic to be trained as they are the only nurse that can see to the patients.

The HIV/AIDS and STI Assistant Programme Manger for the Camdeboo LSA articulated the problem as being that when the patient is referred to the ARV site, “they should be ready to start on treatment. But due to the fact that the staff are not being trained, we find that the clinic doesn’t have enough staff to really be focusing on the ARVs for the patients. The patients are sent to the ARV site and they are not ready yet and this prolongs the period before they can take the ARVs and start the treatment. If we can get a chance to train them from the facility level, this will speed up the process in terms of how long it takes for patients to get onto the treatment programme.”¹⁰⁶

Thus, the number of people who are currently on treatment who have been referred from the feeder clinic reflects the lack of capacity at the feeder clinic level, and not a lack of demand in those areas. This is highly problematic as it means that the Eastern Cape Department of Health is not aware of the real need in the area, and instead the reporting reflects that there are no patients on the waiting list, which gives the impression that health services are meeting the need, whereas in reality the need is unknown because the current structure of the PHC system is incapable of identifying the need due to delays in procedures as a consequence of staff shortages.

Another problem compounding the ARV Clinic’s ability to place people on treatment is that the shortage of staff at the feeder clinics means that patients cannot be back-referred to the clinics to continue treatment from there, but instead travel to the ARV clinic once a month to stay on the programme. This means that fewer new patients can be placed on the programme, as patients who could have been referred back to the feeder clinics are using resources and occupying spaces on the programme that could be filled by new patients.

¹⁰⁴ Interview with Professional Nurse at Bavians Clinic, Steytleville, 10 August 2007.

¹⁰⁵ Interview with ARV Clinic’s Assistant Director, Graaff-Reinet, 28 August 2007.

¹⁰⁶ Interview with the HIV/AIDS and STI Assistant Programme Manger for the Camdeboo LSA, Graaff-Reinet, 30 August 2007.

As the Assistant Director of the ARV clinic states, “The problem is that we cannot back-refer patients. We need to so that we can get a whole lot more people on the programme, but how is the one nurse at the clinic going to cope with the back-referral? Especially given the fact that the nurses have not received adequate training because our budget hasn’t been loaded.”¹⁰⁷ As at the end of August 2007, iThemba Clinic recorded that there were no back-referrals of patients on ARVs to the feeder clinics.¹⁰⁸

The HIV/AIDS and STI Programme Manager for the LSA suggests that it is not merely a matter of training nurses, but that the entire structure of the PHC system needs to be re-examined due to the additional burden that HIV-related illnesses and procedures place on the system:

It is not a case of just giving out medication. There is counselling needed. We are told that they will give us Community Care Workers. Community Care Workers can be trained to a certain level but they do not have the in-depth insight into the actual illness. We are really appealing that we need to re-examine and say that our organogram is not adequate for delivering health care. You at least need four nurses in a clinic. One nurse could be on leave, another nurse can then go on training quite freely knowing that there are two nurses remaining that can continue to do the work that is necessary. We are now sitting with a case of only two nurses in a clinic. One nurse might be ill and so we can’t pull the remaining nurse out to come on training, so that nurse loses out. Or maybe they are both there but we are leaving one nurse behind who needs to do all the other nurses’ work. And we know that while that nurse is on training, the nurse that we have left behind is going to inevitably be ill and stress out. We are programme managers that need to go out there and see that our programmes are implemented but eventually we feel so frustrated that we feel we need to go out there and implement it ourselves, but we can’t stay there to sustain it.¹⁰⁹

Another issue is that the current infrastructure of clinics is not conducive to the procedures associated with the Primary Health Care (PHC) system when it comes to ARV rollout. “They [the clinics] were not originally planned to be PHC centres. We are seeing it over and over again. To offer VCT you should actually have a VCT room where there is privacy and no disturbances. The building often doesn’t lend itself to that. So there is a nurse doing counselling in a consulting room with a telephone ringing constantly. She has got to lock the door so that nobody comes in to fetch whatever they need.”¹¹⁰ This may be contributing to people not accessing the clinics regarding ARV treatment as they know of the bottlenecks and problems of the programme.

An example of the human resource constraints faced by the feeder clinics is that of the Willowmore Clinic. A post of VCT nurse exists on the clinic’s staff establishment. This

¹⁰⁷ Interview with ARV Clinic’s Assistant Director, Graaff-Reinet, 28 August 2007.

¹⁰⁸ iThemba Clinic, Midland Hospital, Monthly Report, August 2007, Compiled by ARV Co-ordinator

¹⁰⁹ Interview HIV & AIDS & STI Programme Manager for the Camdeboo LSA, Graaff- Reinet, 30 August 2007.

¹¹⁰ Interview HIV & AIDS & STI Programme Manager for the Camdeboo LSA, Graaff- Reinet, 30 August 2007.

post was vacant for eight months and has thus only been filled for three months. When the nurse arrived, there was a backlog of “approximately” thirty patients who were HIV positive and needed to be assessed for eligibility for treatment. Three months into this post being filled, the backlog has still not been addressed as the nurse was involved in lightening the load in the daily treatment of all patients. To date only seven of the ‘approximately’ thirty HIV-positive patients at this clinic have been placed on the treatment programme while the CD 4 count and viral load test results are awaited for the remaining patients.¹¹¹

Transport:

One of the key challenges faced by the Midland ARV Clinic in Graaff-Reinet is the vast distances between the ARV clinic and some of the feeder clinics, some of which are as far as 170 km away. The current procedure is that patients who need to be placed on the treatment programme at the Midland ARV Clinic are transported by the ARV clinic from the towns in which the feeder clinics are situated. Thereafter, every patient must return to the ARV clinic monthly to collect their medication. This is causing great challenges for the ARV Clinic in that there is only one 8-seater Patient Transport Vehicle (PTV) available to the Clinic twice a week.

This vehicle leaves the site at 4h00 in the morning and is required to pick patients up at all the feeder clinics in the entire area. At the end of the day, the patients are transported back to these towns which lie in opposing directions to Graaff-Reinet. Although none of the feeder clinics have complained about the current transporting procedures, this is an issue that is placing huge strain on the staff at the ARV Clinic. The Assistant ARV Director at the Clinic is concerned that the current set up will not be sustainable in the future as more patients commence treatment.

The proposed solution has been to outsource this function to private transport companies who have registered supplier numbers. However, due to the fact that the ARV’s Clinic budget was delayed in being transferred, this option was not available as a viable solution. This state of affairs remains, given the insufficient allocation that was transferred to the Clinic in September 2007. This is of grave concern as the issue of transporting patients to and from the ARV Clinic has been highlighted continuously as an area that “desperately needs solutions” at the ARV stakeholder meeting held at the LSA offices.¹¹²

Another proposed solution is to accredit the Willowmore Hospital as an additional ARV site in the LSA, which would be able to serve the needs of Rietbron, Willowmore, Klipplaat and Steytlerville, which are all over 130 km¹¹³ from the ARV Clinic.¹¹⁴ This would decrease the number of kilometres travelled in order to transport patients from these feeder clinics to Graaff-Reinet. According to the Midland Hospital CEO, the provincial department is in the process of assessing Willowmore as a potential ARV site.¹¹⁵ However, the challenge is that in order for this to occur, additional staff would need to be recruited. It would also need to be ensured that the same problems and

¹¹¹ Interview with VCT Professional Nurse at Willowmore Clinic, Willowmore, 10 August 2007.

¹¹² Midland Hospital Graaff-Reinet ARV Stakeholders Meeting, 29 August 2007

¹¹³ See Table 1: Patients on Treatment at iThemba Clinic above

¹¹⁴ Interview with Midland Hospital CEO, Graaff-Reinet, 28 August 2007.

¹¹⁵ Ibid.

bottlenecks that have occurred at the Midland Hospital ARV Clinic do not potentially occur at the Willowmore site by addressing such issues before accreditation.

Key findings and recommendations:

1. Planning and Resource Allocations

Finding:

The Eastern Cape Department of Health was the only provincial Department to receive no conditional grant funding for the HIV and AIDS Programme for the 2007/08 financial year up until the 20th of July 2007. This was due to the Department not complying with DoRA in terms of having their HIV and AIDS Business Plan approved timeously. Only once the inconsistencies in the business plan had been rectified could the funds be transferred.

Recommendation:

The Eastern Cape Department of Health needs to urgently address its history of weak planning and its recent failure to submit a satisfactory business plan. The National Department of Health, as well as the provincial and National Treasury, must assist in this regard in order to avoid this occurring in the following financial year. In addition, the Eastern Cape Department of Health needs to account for its failure to comply with DoRA. The Department must also explain what action has been taken against officials responsible for the submission of a deficient business plan.

Finding:

No funds were transferred to the Midland Hospital ARV site in Graaff-Reinet until the 5th of September 2007. This caused a number of constraints on the newly accredited site's ability to place patients on the ARV Programme, including an inability to train health personnel and improve upon current patient transport constraints. The amount that was eventually transferred was not sufficient and only covered half of what had already been spent on the compensation of employees at that site.

Recommendation:

The Eastern Cape Department of Health needs to support newly accredited sites, especially in terms of transferring timeously the funds needed by sites as outlined in their business plans and budget submissions. If this is not possible, the Department should communicate with individual sites as to when the funds should be expected and what procedures should be followed in the interim.

Finding:

The Eastern Cape Department of Health is lagging in terms of addressing the need for ARVs in the province. During the 2006/07 financial year, there were 12 388 patients on the ARV waiting list in the Eastern Cape.

Recommendation:

The Department needs to set its ARV targets in a manner which includes and addresses this backlog, while also reflecting the overall need in the province. The Department thus needs to address all bottlenecks in the ARV Programme in order to get as many people as need be onto ARV treatment, by analysing these issues from the LSA to the District level to the Provincial level. In this way Provincial plans and targets can be set according to the needs at the level of implementation. In addition, the Department must conduct a

thorough analysis of needs in terms of numbers of patients that require ARVs and plan accordingly.

Finding:

The Eastern Cape Department of Health's Comprehensive HIV and AIDS Conditional Grant decreased by 4.39 % in real terms, from R232.07 million in 2006/07 to R233.20 million in 2007/08. This is the allocation on which all the activities outlined in the Department's HIV and AIDS Business Plan is based.

Recommendation:

Given the increase in targets for the HIV and AIDS Programme in terms of VCT, ARV rollout, the accreditation of sites, home-based care and the Prevention of Mother to Child Transmission, National Treasury and the National Department of Health must increase the Eastern Cape Health Department's HIV/AIDS budget in order to ensure increased targets are met. The Eastern Cape Department of Health needs to engage with Provincial Treasury to motivate for an increase in budget allocation for the upcoming financial years. If no further funds are forthcoming, the Department is likely to experience significant cost pressures in attempting to meet its increased targets. The Department must monitor its expenditure closely, thereby enabling it to account to National and Provincial Treasury, and the National Department of Health, on the constraints that it may face given the relatively small increase in budget allocation for HIV/AIDS in the Province.

Finding:

The ART sub-programmes budget allocation has increased by R46.768 million (or 38.33 % in nominal terms) from R122 million in 2006/07 to R168.768 million in 2007/08. This is of concern given the fact that the target for the number of patients receiving ARVs from the 2007/08 financial year has increased by 48%. Thus there has in fact been a decrease in the amount allocated for each patient as set out in the Department's ARV targets. In 2006/07, the Department had budgeted R4 518 per patient on treatment, whereas this has decreased to R4219 per patient for 2007/08.¹¹⁶

Recommendation:

The Department must base its budget allocation for ARV treatment on an analysis of the needs in the Province. The Department needs to assess how many people should be on this programme and then draw up a costed plan accordingly, based on the cost of having each person who needs it on treatment.

Finding:

In the drafting of the Eastern Cape HIV and AIDS Business Plan for the 2007/08 financial year, the Department's submission of its third draft to the National Department of Health contained planned activities that cost R52.114 million more than the conditional grant allocation outlined in DoRA and contained timeframes that referred to the previous financial year.

Recommendation:

The Department must ensure that it reconciles its budget allocation with the planned activities outlined in the Business Plan and that all timeframes are set out accurately.

¹¹⁶ This does not take the effect of inflation into account.

2. Expenditure and Financial Reporting

Finding:

Despite the Department not having received any conditional grant funding for the First Quarter of the financial year, the Department had reportedly spent R54.193 million on this programme from the Department's equitable share allocation.

Recommendation:

The Department must ensure that all equitable share funding that has been used for the HIV and AIDS Programme to compensate for the lack of conditional grant funding is journalized and that these funds are redistributed so as to not compromise other health programmes funded by the equitable share.

Finding:

As at the end of August 2007, the Eastern Cape Department of Health had only spent R54.147 or 23.22% million of its R233.203 million conditional grant allocation, five months into the financial year. It is highly likely that the Department will under spend this conditional grant for this financial year.

Recommendation:

The Department needs to ensure that this allocation is not under spent. Failing this, the Department needs to ensure that sound financial reporting is kept in order for the Department to prove to the satisfaction of National Treasury that the unspent allocation is committed to identifiable projects so that these funds can be kept by the Department in the form of rollover funds. In this way activities costed in the 2007/08 Business Plan can be carried forward and implemented if possible.

Finding:

Numerous inconsistencies are present in the Department's monthly financial reports concerning this conditional grant. The CFO signature is missing on most documents, there is no compliance summary, despite funds not having been received, and certain calculations do not add up.

Recommendation:

The Department needs to ensure that it keeps sound and detailed financial reports to ensure improved planning and budgeting in future financial years. It is also imperative that the Department improves its monthly reporting in order to motivate for a rollover should it be necessary.

3. Human Resources

Finding:

The Midland Hospital ARV Clinic is facing vacancies of critical staff members such as pharmacists, dieticians and a full-time doctor. There is also a discrepancy as to the salary level of the doctor's post.

Recommendation:

Midland Hospital needs to ensure that these posts are filled urgently and that the salary of the doctor is at the level outlined in the Eastern Cape Department of Health's HIV and AIDS Business Plan. The Department should be assisting with this and must address all

challenges that are hindering these posts from being filled. In addition, the Department needs to conduct research into a recruitment and retention plan that addresses these issues.

Finding:

There are also vacancies and staffing shortages at Primary Health Care Centres at the feeder clinic level. This is causing bottlenecks in terms of the number of patients that are being referred to the ARV site at Midland Hospital. This staffing shortage has also resulted in nurses not being able to attend vital training sessions. Consequently, it is impossible for patients to be referred back to the feeder clinics once they have commenced treatment. This means that new patients cannot be entered into the ARV Programme due to the number of patients already being supported by the Midland Hospital Clinic, who technically should have been referred back to feeder clinics.

Recommendation:

The Eastern Cape Department of Health needs to ensure that all clinics are fully staffed and that all staff have received the necessary HIV/AIDS training in order for the ARV Programme to be successfully implemented in this area. This will allow for more patients to be back-referred to the clinics and thus open spaces for more patients to commence treatment at the ARV Clinic.

4. Transport

Finding:

Given the fact that the number of patients on treatment is increasing, there is concern that the current system of transporting patients from the feeder clinics to the ARV Clinic is unsustainable due to the vast distances between some of the feeder clinics and the ARV clinic, and the limited Patient Transport Vehicles (PTV) available to the Clinic. The Clinic had intended to outsource this function, but could not do so due to the late transfer of funds. The amount of funding that was eventually transferred was insufficient to cover these costs.

Recommendation:

The Midland Hospital ARV Clinic needs to clearly articulate in its monthly reports the challenges being faced in terms of transport and motivate for increased allocations. The Department needs to assist the Midland ARV Clinic in solving this issue. In addition, the Department should conduct research into and address what the potential effects and challenges would be if Willowmore Hospital were to be accredited as an ARV site.

Conclusion:

While the Eastern Cape Department of Health's ARV Programme exceeded its 2006/07 targets, this does not reflect a number of problems being faced by, not only by the provincial Department, but individual ARV sites and feeder clinics where this programme is being implemented.

The provincial Department's planning and resource allocation for this programme are of concern. Targets, for the number of patients on ARVs are based on the number of people in need of ART that the Department is *aware* of, but do not take into consideration the number of people who have difficulty accessing primary health care (PHC) services, nor the number of people who know their HIV status but have not been

through the necessary medical tests to determine whether they need ART due to capacity constraints at the PHC level. It would also appear that the Department has not factored in the growing annual HIV incidence rate in calculating their intended targets. Essentially, the Department is unaware of what the actual need for ART in the Province is. Thus, even if the Department does meet its targets, this is not an accurate indicator as its performance in this regard since the Department should be providing ART to all those who need it.

The Department must conduct in-depth research into what the need for ART in the Province really is, and must also take into consideration bottlenecks and challenges highlighted at the sites of delivery when drawing up its targets and plans for this critical programme. These include human resource capacity constraints due to understaffing and a difficulty in recruiting and retaining staff at ARV clinics themselves, as well as at the PHC feeder clinics where patients need to be prepared and identified for treatment and transport problems due to distances between the ARV Clinics and feeder clinics and a shortage of vehicles to transport patients. The Department should collate all information regarding these challenges, as well as budget requirements and plans from the LSA level, and feed these into District plans. These should in turn inform the Department's provincial business plan and targets, as well as its motivations for necessary budget allocations for this Programme.

However, setting targets is not the only problem facing the Department in terms of planning. As illustrated by the Eastern Cape Department of Health's 2007/08 Business Plan not being timeously approved in order for conditional grant funding to be transferred, the Department needs to address the issue of poor planning by taking all measures possible to rectify this, such as requesting the National Department to assist in the drawing up of the 2008/09 Business Plan. It is critical that the Eastern Cape Department of Health reflect on the circumstances which led to its plan not being approved and ensure that these issues are addressed to avoid this occurring in the future.

The Department's monthly financial reporting for this conditional grant is critical as it will account for the Department's expenditure of these funds. This is vital given the late transferal of funds which is likely to lead to the Department under spending this grant and is likely to lead to the Department requesting the rollover of these funds for use in the following financial year. The Department also needs to clearly document the use of equitable share funds for the HIV/AIDS Programme that should have been dedicated to other health programmes. This will indicate to the Department how much it spent on the programme in total, and hence the Department will be able to budget for this programme more accurately for the upcoming financial year.

The Eastern Cape and National Departments of Health need to ensure that these factors are taken into account in drawing up the 2008/09 HIV/AIDS Business Plan and motivating for adequate budget allocations in order to ensure that the rollout of this programme meets the need of all Eastern Cape citizens.