Performance based funding from the Global Fund to fight AIDS, Tuberculosis and Malaria:

A case study of Grant SAF-304-G04-H in the Western Cape, South Africa

Trude Holm Naimak
NMKTRU001

A minor dissertation submitted in fulfilment of the requirements for the award of the degree of Master of Philosophy in HIV/AIDS and Society

Faculty of Humanities
University of Cape Town
2006

This work has not been previously submitted in whole, or in part for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: Date:

Abstract

After one year with access to the SAF-304-G04-H grant, a performance based funding from the Global Fund to fight AIDS, Tuberculosis and Malaria, the Western Cape Province has been able to race ahead with the antiretroviral rollout. The Global Fund's contribution has helped enable the province to provide antiretroviral treatment to 65% of the people who desperately need it, which is a stark contrast to the South African national average receiving treatment of 10%.

This dissertation illustrates how the Global Fund grant has clearly met and in some cases exceeded its targets particularly in relation to antiretroviral (ARV) treatment in its first year. Based on the research carried out as part of the preparation of this dissertation, it became clear that the Western Cape's progressive and committed management team was instrumental in successfully providing increased access to ARV treatment compared to other provinces. Other factors that have contributed to the success of the grant project include the fact that in 1999 the province first initiated the provision of antiretroviral drugs to help prevent HIV positive women transmitting the infection to their infants. With the experiences gained from both the introduction of treatment drugs and from the valuable experience gained from the pilot ARV rollout projects in Khayelitsha and Gugulethu, the battle against HIV and AIDS has grown stronger.

The findings of this dissertations support the impression that the arrival of the funds from the Global Fund grant and other national funds, has created a basis for a successful programme to provide ARV treatment for many years to come.

Glossary of terms:

3 by 5	World Health Organization initiative to put 3 million people on antiretroviral therapy for HIV/AIDS worldwide by the end of 2005
AIDS	Acquired immune deficiency syndrome
ANC	African National Congress
ARV	Antiretroviral (drug)
ART	Antiretroviral Therapy
CBO	Community-based organisation
CCM	Country Co-ordination Mechanism
CHC	Community Health Clinic
DoH	Department of Health
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	Highly Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
Incidence	The number of new infections in a given period of time
LFA	Local Fund Agent
MSF	Médecins Sans Frontières (Doctors without Borders)
MTCT	Mother-to-child transmission (of HIV)
NAC	National AIDS Council
NGO	Non Governmental Organisation
PAWC	Health Department of the Provincial Administration of the Western Cape
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission (of HIV)
PR	Principal Recipient
Prevalence	The percentage of a population estimated to be infected with a disease
TB	Tuberculosis
TRP	Technical Review Panel
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing (for HIV)
WHO	World Health Organization

Table of Contents

Table of Figures

Introduction

More than 40 million people worldwide are HIV positive. Since AIDS was first discovered more than 25 million people have died as a result of the disease. Antiretroviral treatment is widely available in developed countries, while access to antiretrovirals (ARVs) in poorer countries has been inadequate. The World Health Organisation estimated in June 2005 that only 1 million people out of the 6 million people needing the life saving ARV medication were receiving it (WHO, 2005).

Access to antiretroviral treatment has caused much controversy in South Africa. With more than 5.2 million South Africans affected with HIV/AIDS, South Africa is the country with the highest number of people infected, and AIDS is the country's number one killer (Dorrington *et al*, 2001). The arrival of antiretroviral treatment (ART) has given hope to millions of people living with HIV/AIDS; however access and commitment, from the South African government, to provide the life saving drugs has been limited.

The Provincial Department of Health in the Western Cape was the first to start providing ART in South Africa. As funds for ART in South Africa were limited, the department applied for external funding from the Global Fund to fight AIDS, Tuberculosis and Malaria in 2003. The proposal was successful, allowing the Western Cape to rapidly increase their efforts on AIDS treatment though out the province by employing more people on the ART campaign. This has resulted in the Western Cape rollout being hailed as the ARV success story of the country, with more than 11 000 people living with HIV/AIDS receiving ART, a quarter of whom are funded by the Global Fund (Cloete, 2005, personal comm., 30 Aug). It was further estimated that at the end of 2005 65% of those in need of ARV treatment in Western Cape would have had access to the lifesaving drugs, a figure considerably higher than the South African national average of 10% (Herman, 2006).

This dissertation will explore and demonstrate that the Global Fund grant in the Western Cape is a successful project grant. It will show how it in its first year the project grant has met the targets and objectives set by the Global Fund, especially those concerned with antiretroviral treatment. Furthermore this dissertation seeks to identify the key factors, which can be attributed to the success of the Global Fund grant given to the Western Cape Provincial Health Department. It also provides an historic overview of ARV treatment in the Western Cape.

Dissertation Structure

The ***first chapter*** provides an introduction to HIV/AIDS. This enables the reader to understand terms and issues around HIV and AIDS. It covers areas such as the discovery of AIDS, how HIV prevalence estimates are made and what antiretrovirals are. The latter half of the chapter focuses on access to ARVs in South Africa in light of AIDS policies. This chapter provides the reader with a better understanding of the political issues that will be referenced through out the entire dissertation.

The ***second chapter*** describes the research methodology. It provides details of how the primary research for this *dissertation* was conducted, who was interviewed during the course of the research, and why those individuals were of particular interest.

The ***third chapter*** concentrates around HIV/AIDS in the Western Cape. It gives the reader an insight into the historic background of ARV treatment and highlights how committed the Western Cape were to HIV/AIDS at a much earlier stage than other provinces.

The ***fourth chapter*** provides the reader with information about the Global Fund and its quest to fight AIDS, Tuberculosis and Malaria. It seeks to provide a comprehensive overview of the institution and how it operates. It provides an understanding of why the performance review process is such an essential part of the Global Fund.

The ***fifth chapter*** provides a detail description of the grant (SAF-304-G04-H) given to the Western Cape. Here it is argued that the grant is a successful grant, mainly due to it having met the targets set by the Global Fund. The last part of this chapter discusses the general rollout of antiretrovirals, in the Western Cape and its relation to the Global fund.

The ***sixth chapter*** presents the main finding of this research. It argues that factors such as partnerships, previous experience, good management, timing and synergy played an important role in the success of the grant.

The ***seventh chapter*** outlines main challenges facing the Western Cape's rollout programme.

CHAPTER 1: HIV/AIDS and the South African epidemic

UNAIDS estimated that some 40 million people worldwide were living with HIV/AIDS in 2005. HIV/AIDS has been described as the most devastating plague in modern times, killing over 25 million people thus far (UNAIDS, 2005). HIV has been around for 25 years (Abdool Karim, 2005, p.32), and it is spreading at an alarming high rate with an estimated 14 000 people becoming infected each day (UNAIDS, 2005). This chapter of the dissertation will explore the following questions: What is HIV/AIDS, how does it spread, and how can it be treated? This will provide the reader with a good basic understanding of the epidemic before delving into further issues surrounding HIV/AIDS.

AIDS was first discovered in June 1981 in homosexual men in Los Angeles. At first researchers assumed the disease only affected homosexuals; however in December 1981 it became known that the disease also affected injecting drug users (IDUs) and other groups, the perception then changed. By 1982 the disease was named Acquired Immuno Deficiency Syndrome (AIDS), however the discovery and isolation of the Human Immunodeficiency Virus (HIV) was not until 1983 (Abdool Karim, 2005, p.32).

HIV is a retrovirus which attacks CD4 + T- cells where it integrates itself into human DNA, and gradually destroys the immune system (Morris and Cilliers, 2005, p.79). HIV enters the body through unprotected sexual intercourse, intravenous drug use with needles, transmission from mother to child in pregnant women, use of infected blood for blood transfers, or through direct contact with open wounds. Within the first weeks of infection there is a high level of virus replication, but after a few weeks the immune system responds to HIV and the viral load declines (Morris and Cilliers, 2005, p.85). HIV positive people thus look healthy and normal for the first years of infection. It is only when the virus has managed to destroy the immune system (by reducing the number of CD4 cells) and increasing amount of opportunistic infections like Tuberculosis, occur as a result of the weakened immune system, that the patient develops AIDS. The time between HIV infection and the development of AIDS takes on average 8-10 years (*ibid*).

HIV/AIDS is an international epidemic with cases on every continent (UNAIDS, 2005). It is still spreading fast even 25 years after its first discovery. The epidemic is still growing almost

everywhere, however fastest in Eastern Europe and Russia, with only a few countries like Brazil and Uganda having experienced a decline in infections (UNAIDS, 2005). As illustrated below UNAIDS estimates that in 2005 over 40 million people were living with HIV/AIDS. A total of 4.9 million people became infected with HIV in 2005, while a further 3.1 million were estimated to have died of AIDS in 2005 (UNAIDS, 2005). At the present time there are no cures or reliable vaccines for AIDS and without antiretroviral drugs the patient will die shortly after having developed AIDS.

The table below from UNAIDS gives a regional summary of HIV/AIDS in 2003 and in 2005. From the table one can see that Sub-Saharan Africa is by far the region hardest hit by HIV/AIDS. Over 25 million people are infected with HIV/AIDS in this region, making Sub-Saharan Africa alone account for 2/3 of all people living with HIV and AIDS.

Regional HIV and AIDS statistics and features, 2003 and 2005

	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult and child deaths due to AIDS
Sub-Saharan Africa				
2005	25.8 million [23.8–28.9 million]	3.2 million [2.8–3.9 million]	7.2 [6.6–8.0]	2.4 million [2.1–2.7 million]
2003	24.9 million [23.0–27.9 million]	3.0 million [2.7–3.7 million]	7.3 [6.7–8.1]	2.1 million [1.9–2.4 million]
North Africa and Middle East				
2005	510 000 [230 000–1.4 million]	67 000 [35 000–200 000]	0.2 [0.1–0.7]	58 000 [25 000–145 000]
2003	500 000 [200 000–1.4 million]	62 000 [31 000–200 000]	0.2 [0.1–0.7]	55 000 [22 000–140 000]
South and South-East Asia				
2005	7.4 million [4.5–11.0 million]	990 000 [480 000–2.4 million]	0.7 [0.4–1.0]	480 000 [290 000–740 000]
2003	6.5 million [4.0–9.7 million]	840 000 [410 000–2.0 million]	0.6 [0.4–0.9]	390 000 [240 000–590 000]
East Asia				
2005	870 000 [440 000–1.4 million]	140 000 [42 000–390 000]	0.1 [0.05–0.2]	41 000 [20 000–68 000]
2003	690 000 [350 000–1.1 million]	100 000 [33 000–300 000]	0.1 [0.04–0.1]	22 000 [11 000–37 000]
Oceania				
2005	74 000 [45 000–120 000]	8200 [2400–25 000]	0.5 [0.2–0.7]	3600 [1700–8200]
2003	63 000 [38 000–99 000]	8900 [2600–27 000]	0.4 [0.2–0.6]	2000 [910–4900]
Latin America				
2005	1.8 million [1.4–2.4 million]	200 000 [130 000–360 000]	0.6 [0.5–0.8]	66 000 [52 000–86 000]
2003	1.6 million [1.2–2.1 million]	170 000 [120 000–310 000]	0.6 [0.4–0.8]	59 000 [46 000–77 000]
Caribbean				
2005	300 000 [200 000–510 000]	30 000 [17 000–71 000]	1.6 [1.1–2.7]	24 000 [16 000–40 000]
2003	300 000 [200 000–510 000]	29 000 [17 000–68 000]	1.6 [1.1–2.7]	24 000 [16 000–40 000]
Eastern Europe and Central Asia				
2005	1.6 million [990 000–2.3 million]	270 000 [140 000–610 000]	0.9 [0.6–1.3]	62 000 [39 000–91 000]
2003	1.2 million [740 000–1.8 million]	270 000 [120 000–680 000]	0.7 [0.4–1.0]	36 000 [24 000–52 000]
Western and Central Europe				
2005	720 000 [570 000–890 000]	22 000 [15 000–39 000]	0.3 [0.2–0.4]	12 000 <15 000
2003	700 000 [550 000–870 000]	20 000 [13 000–37 000]	0.3 [0.2–0.4]	12 000 <15 000
North America				
2005	1.2 million [650 000–1.8 million]	43 000 [15 000–120 000]	0.7 [0.4–1.1]	18 000 [9 000–30 000]
2003	1.1 million [570 000–1.8 million]	43 000 [15 000–120 000]	0.7 [0.3–1.1]	18 000 [9 000–30 000]
TOTAL				
2005	40.3 million [36.7–45.3 million]	4.9 million [4.3–6.6 million]	1.1 [1.0–1.3]	3.1 million [2.8–3.6 million]
2003	37.5 million [34.0–41.9 million]	4.6 million [4.0–6.0 million]	1.1 [1.0–1.2]	2.8 million [2.5–3.1 million]

Figure 1 ESTIMATED REGIONAL HIV AND AIDS STATISTICS AND FEATURES 2003 - 2005 (UNAIDS, 2005)

The 2005 UNAIDS epidemic update estimates that 29.5% of South Africans (aged 15-49) are living with HIV/AIDS, which makes South Africa the country with the highest total number of HIV positive people in the world.

The scale of the HIV/AIDS epidemic

To understand the enormity of HIV/AIDS it is important to understand how estimates of HIV infection levels are made. HIV/AIDS statistics are usually extrapolated from annual antenatal surveys, which are generated into estimates (Gouws and Abdool Karim, 2005, p.52). Firstly the local/regional antenatal prevalence rates are collected by counting the number of HIV positive pregnant women accessing antenatal care where they are tested for HIV in the various public clinics (Department of Health, 2005). The local/regional surveys are then used to determine the national HIV antenatal prevalence statistics. This data is extrapolated to the sexually active population, often described as the age group between 15 and 49 (UNAIDS, 2005). It is this estimation process which proves the basis for most national estimates of HIV prevalence and incidence.

The antenatal prevalence in South Africa has risen dramatically over the last 15 years. From a low 0.8% in 1990 to 29.5% in 2005, with some areas showing more than 1 out of 3 pregnant women testing positive for HIV (Department of Health, 2005).

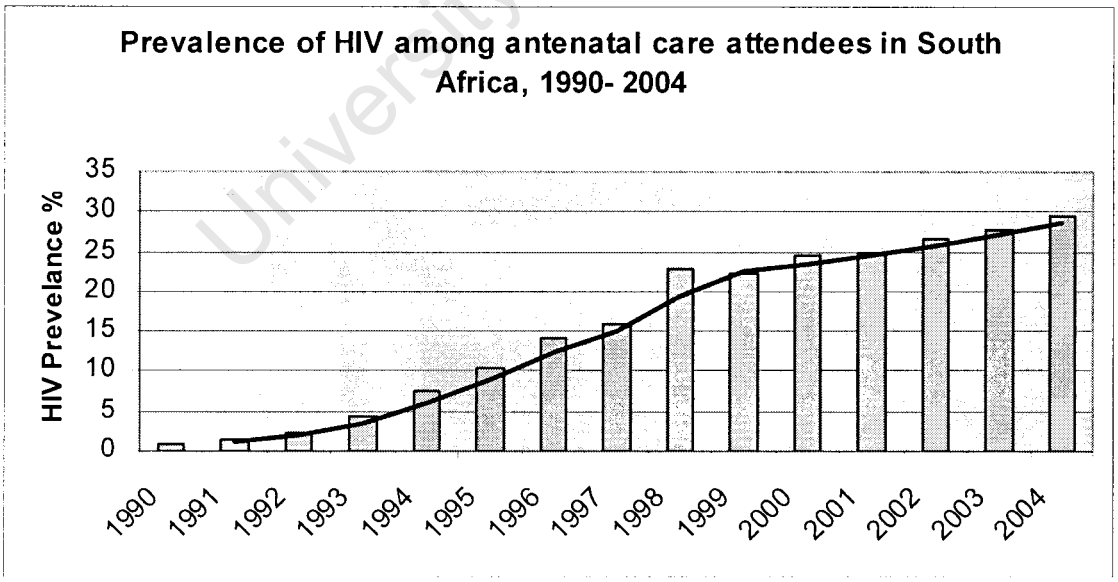


Figure 2 : ESTIMATED PREVALENCE OF HIV AMONG ANTENATAL CARE ATTENDEES IN SOUTH AFRICA, 1990- 2004 (DEPARTMENT OF HEALTH, 2005)

Access to ARVs

For those who are living with HIV/AIDS today, medical science has turned 'AIDS - the death sentence' into 'AIDS - the chronic disease'. In Western Europe and in the United States the number of people dying of AIDS has been reduced, despite increases in new HIV infections (UNAIDS, 2005). By taking Highly Active Antiretroviral Treatment (HAART) [1] correctly for the rest of life, HIV/AIDS becomes a 'chronic disease' and not an immediate death sentence. Access to antiretroviral treatment (ART) has, despite being reported to work as early as in 1996 at the International AIDS Conference in Vancouver, been limited in most parts of the world (WHO, 2005).

Highly Active Antiretroviral Treatment is usually a combination of three ARV drugs which together suppress the HI virus, allowing a rise in CD4 cells (Wood, 2005, p.506). ARVs delay the progression of HIV, strengthening the immune response and allowing the immune system to recover from and fight off infection (*ibid*). Since a high count of CD4 cells is essential for a strong immune system, the average CD4 count for a healthy individual is around 1000, a rise in CD4 cells from 200 to 800 has a dramatic effect on a patients well being (WHO, 2005). ARVs manage to kick patients back into good health, because it helps HIV positive people to fight off opportunistic infections. HIV at its worst can eliminate all CD4 cells in a body (eliminate the immune system), which allows the patient to die of any infection, even from the flu. However ARVs not only prevent people from dying from AIDS, they improve quality of life, and allow people living with HIV/AIDS to live normal, healthy lives (Wood, 2005, p.505-506). When taken correctly, triple therapy can often lead to undetectable HIV viral levels (*ibid*), making transmission of HIV less frequent (Nattrass, 2004, p.118). ARV treatment is thus not only beneficial for the individual receiving the drugs, it is also beneficial in terms of HIV prevention..

Through global initiatives like the Global Fund to fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan For AIDS Relief (PEPFAR) access to antiretroviral treatment has been made increasingly possible. Despite this, most people in need of ARV treatment still do not have access to the life saving drugs. With initiatives like the World Health Organization's (WHO) '3 by 5' (treat 3 million HIV positive by 2005) only reaching around 1

[1] HAART is made up by a combination of antiretrovirals (ARVs), which suppress the viral load, making the immune system stronger

million people by June 2005 (WHO, 2005). Despite falling short of the WHO 3 million target, there has been a dramatic increase in people on ARV Treatment, from 400 000 in 2003 and the initiative has managed to create more attention around ARV Treatment (WHO, 2005) as can be seen in the map below of the world wide coverage of ARV Treatment.

Figure 3 MAP SHOWING PERCENTAGE OF PEOPLE ON ANTIRETROVIRAL TREATMENT, WHO 2005

Despite the fact that there has been a dramatic decline in ARV drug prices (WHO, 2005), the Global Fund has not received more than half of the funds it needs to fight AIDS, Tuberculosis and Malaria, and not enough money has been committed by countries and political leaders to even achieve the '3 by 5' goal (Global Fund, 2005f, WHO, 2005). Nevertheless, external funds have been able to provided free ARV Treatment in countries like Swaziland and Botswana. However access to antiretroviral treatment in South Africa has not been as smooth and has been strewn with mistrust and denial.

HIV/AIDS policies in South Africa

Despite that the first cases of AIDS were reported in South Africa in 1982 (van der Vliet, 2004), and antiretroviral treatment was available through private health care from 1996

onwards (Wood, 2005, p. 505), it took many years for ARVs to become available in the public health system. This was despite an alarming increase in HIV cases in South Africa since the first cases in 1982. In 1990 antenatal prevalence from random pregnant women showed that 0.8% were HIV positive and in 1991 the number had almost doubled to 1.5% (Department of Health, 2005), which is a clear indication that the epidemic was spreading fast in the heterosexual, predominantly African, population.

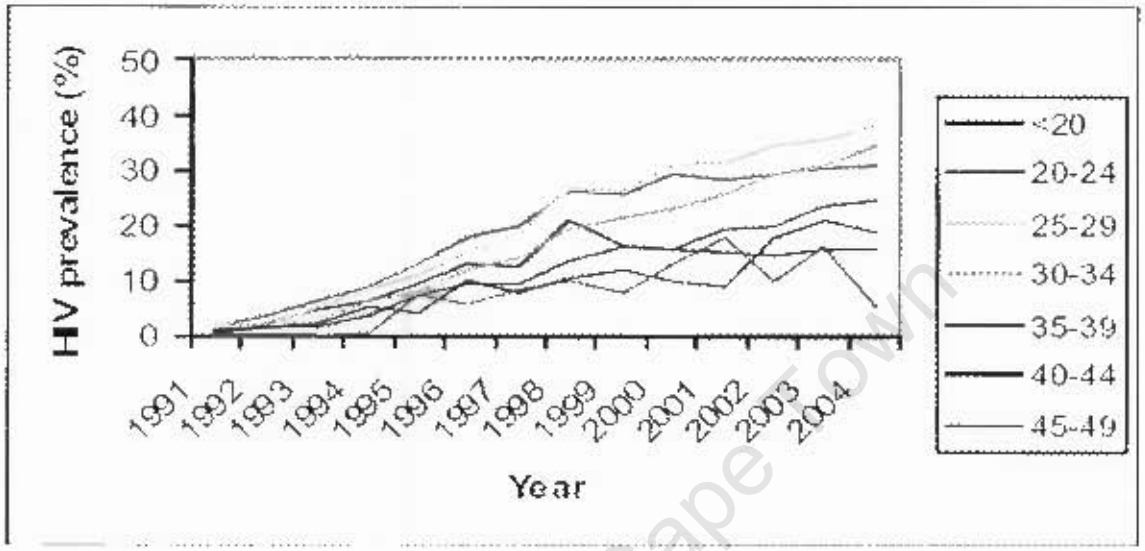


Figure 4 ESTIMATED HIV PREVALENCE TRENDS BY AGE GROUP AMONG ANTENATAL CLINIC ATTENDEES, SOUTH AFRICA: 1991 – 2004 (DEPARTMENT OF HEALTH, 2005).

During apartheid, little was done to curb the spread of the epidemic. According to Ivan Toms, an AIDS activist in 1990: 'There is no possibility that the present government could, even if it has the inclination, run an effective campaign to limit the spread of HIV infection. It has no credibility or legitimacy whatsoever among blacks' (quoted in van de Vliet, 2004, p. 52). At a conference in 1992 the African National Congress (ANC), the old apartheid health department, AIDS activists and health professionals formed the National AIDS Committee of South Africa (NACOSA), the result of which was an 'AIDS Plan' developed in 1993 (Nattrass, 2004, p. 42).

Two of the eight people drafting the plan were later to become South African Health Ministers (Dr. Nkosazana Dlamini-Zuma and Dr. Manto Tshabalala-Msimang) (van der Vliet 2004, p. 53). In 1994 great expectations were held for the new democratic government led by Nelson Mandela. The then new health minister, Dr. Nkosazana Dlamini-Zuma, adopted the NACOSA 'AIDS Plan' as the government's AIDS strategy and many had hoped the AIDS programme director would be located in the presidential office and not in the Health Ministry where it

remained. It is suggested by van der Vliet (2004, p.53) that this factor may have contributed to the AIDS Plan diminishing in priority and becoming just another one of the many challenges facing the new government.

Nelson Mandela had originally intended to make HIV/AIDS one of his government's priorities, and later expressed regret that more emphasis had not been placed on stopping the epidemic when there was still hope of avoiding a public health disaster (Heywood, 2005, p.376).

With AIDS not being at the forefront of the government's policies, a somewhat sad attempt was made to stop the epidemic (Sarafina and Virodene), which resulted in controversy, denial and mistrust which is still present in South Africa today.

Sarafina and Virodene

In 1995 the first of the attempts to educate the people about HIV and AIDS was made by the Department of Health commissioning a musical, Sarafina II, with the intention of making HIV/AIDS prevention through a cultural play (van der Vliet, 2004, p.55). The idea was to produce a sequel to the widely popular film 'Sarafina'. It was an expensive production, absorbing R14.2 million of the AIDS budget. AIDS activists and experts were not consulted, and felt excluded from the process (*ibid*). In addition, the money was from the European Union and the government had failed to ask for permission to spend the funds specifically on a musical. All this resulted in public protest and disagreements, which led to an investigation by the Public Protector, and a successive cancellation of the project (Nattrass, 2004, p.45). Sarafina II marked the start of mistrust between AIDS activists, AIDS experts and the national Department of Health.

Still, whilst the Sarafina investigation was carried out, in 1997 the South African government managed to cause another stir around AIDS with a proposal of introducing Virodene PO58, an AIDS 'cure' drug (Deane, 2005, p.539). At this time it was well documented that ARVs were effective, however the government proceed to claim that this drug would cure AIDS. The drug was developed by three scientists in Pretoria, and was backed by senior officials and government ministers to be a miracle cure for AIDS. Patient testimonies were put forward claiming that they were cured from AIDS. The drug, however, had not completed necessary

tests, and it was rejected several times by the South African Medicines Control Council (MCC) (*ibid*). None of the researchers that put Virodene forward were experts on HIV and AIDS (*ibid*, p. 540).

Furthermore activists, experts and the international medical community started questioning the effects of Virodene, which led to a joint enquiry by the Gauteng Provincial Department of Health and the University of Pretoria of the drug. The result of which was the finding that Virodene contained the extremely toxic industrial solvent dimethylformamide, which could cause cancer and liver damage. In addition patients that had taken the drug had reported irritations (Deane, 2005, p.539). Therefore the MCC refused to allow the use of Virodene whilst AIDS patients continued to beg for access to the drug (Nattrass, 2004, p.46). An additional outcome of the investigation were allegations around the government's financial involvement in Virodene (Deane, 2005, p.540; Nattrass, 2004, p.46).

It was widely recognised that ARV treatment is an effective medication for people infected with HIV, however the South African government managed to cause confusion around established medical facts, marking the Virodene scandal as the start of the government questioning the reliability of science. This became prominent when Thabo Mbeki became the South African President in June 1999 (Nattrass, 2004, p.46). Following President Mbeki's choice to instead of engaging in constructive debates rather accused those who opposed him of 'plotting against him', which ultimately lead to the replacement of the then leader of the MCC and other key personnel (Nattrass, 2004, p.46). People, who had hoped for access to antiretroviral treatment through the public health system, were naturally disappointed by the government's policies.

AZT

In October 1998 Health Minister Dr. Nkosazana Dlamini-Zuma announced that she and nine provincial health ministers had decided to focus on HIV prevention and not make AZT (zidovudine) available to pregnant women (van der Vliet, 2004, p.56). This was a blow for activists who wanted to use antiretrovirals to prevent HIV infection in infants. In 1998 it was well known that AZT treatment could reduce the chance of HIV transmission from mother to child by 50% (Abdullah, 2005, p. 249; Goemaere, 2005, personal comm., 5 Aug). Dr.

Nkosazana Dlamini-Zuma claimed the drug was too expensive and that the government could not be responsible for the prevention of mother-to-child-transmission (PMTCT). She said that the cost of testing all pregnant women, providing counselling and providing formula feeding was far too high for the government to cope with. Dr. Nkosazana Dlamini-Zuma still persisted in making these claims even while scientists and economists showed that PMTCT was affordable (Nattrass, 2004, chapter 3). Allegations around AZT being toxic started to surface and naturally created a storm of protests against the government. In the middle of these issues, on 10 December 1998, the activist organisation, Treatment Action Campaign (TAC), was born (Robins, 2004, p.662).[2] The international face of TAC, Zackie Achmat (a former anti-apartheid gay activist and openly HIV positive), together with the rest of the TAC leaders, later turned out to be the major activist organisation in South Africa, particularly at the forefront for demanding treatment.

The first provincial rebellion against national AIDS policies came in 1999 when the Western Cape, at the time not under ANC control, decided to pilot AZT and formula feeding at two sites in Cape Town in order to reduce mother to child transmission of HIV (Abdullah, 2005, personal comm., 23 Sept). This was not popular with the national government, who accused the Western Cape of playing games with peoples lives by using the rumoured toxic drug AZT (Goemaere, 2005, personal comm., 5 Aug).

After the 1999 elections, Dr. Nkosazana Dlamini-Zuma became the foreign minister, whilst Dr. Manto Tshabalala-Msimang became the new health minister. Hopes that the new health minister would be strongly committed to fighting AIDS were soon crushed. The Mbeki government and Dr. Manto Tshabalala-Msimang caused even greater controversy than the previous administration. The outrage started in October 1999 with President Mbeki addressing the National Council of Provinces, claiming AZT to be toxic (van der Vliet, 2004, p.58). Dr. Manto Tshabalala-Msimang shortly thereafter put forward that AZT weakened the immune system and could lead to mutations in babies (*ibid*). The fact AZT was on the list of the World Health Organisation's essential drugs, and that the US Centres of Disease Control and the South African MCC had approved it, appeared not to affect the president or the health minister.

Then in January 2000, the government appointed the South African National AIDS Council

[2] For more information on TAC see www.tac.org.za

(SANAC), causing further criticism. The council comprised of 15 cabinet ministers, one representative from an AIDS organisation, three representing sport, hospitality and 'celebrities', and two traditional healers (van de Vliet, 2004, p.58). There were no scientists, no medical practitioners; nobody representing the big AIDS organisations, such as TAC, and no representatives from MCC or the Medical Research Council. This left the activists extremely disappointed as they had hoped for a multi-sectoral and inclusive council.

AIDS dissidents

In early 2000 the situation got worse for AIDS activists, when President Mbeki set up the 'Presidential International Panel of Scientists on HIV/AIDS in Africa'. Dissidents of the conventional scientific view that AIDS is caused by HIV, such as David Rasnick and Peter Duesberg, were invited onto this panel (van der Vliet, 2004, p.59). The dissidents questioned the very existence of AIDS and believed that AIDS was caused by poverty and not by HIV. Such views appeared to have the support of President Thabo Mbeki (Nattrass, 2004, p.49; van der Vliet, 2004, p.59). This created confusion around the understanding and importance of antiretroviral treatment, with the dissidents going as far as claiming that antiretroviral drugs actually gave people AIDS. Many published articles such the illustration below highlighted the growing frustration of the public and activists.

In addition in April 2000, President Mbeki took the unprecedented step of writing to world leaders, such as the UN Secretary General Kofi Annan, British Prime Minister Tony Blair and US President Bill Clinton, requesting them to revisit the issue of AIDS (van der Vliet, 2004, p.59). This letter caused massive criticism, as it was rumoured to disclose to the major world leaders the accusation that HIV did not in fact cause AIDS.

Figure 5 : COMIC ILLUSTRATION OF THE PRESIDENTIAL INTERNATIONAL PANEL OF SCIENTISTS ON HIV/AIDS IN AFRICA' (MAIL & GUARDIAN 16 MARCH 2000)

South Africa was chosen to host the July 2000 International AIDS conference in Durban. The conference coincided with the height of the debate surrounding the dissident views. This worried the conference chairperson, Professor Coovadia, who pleaded with President Mbeki to steer clear from scientific debates (van der Vliet, 2004, p.59). Preceding the conference the journal Nature published the article 'Durban declaration' where 5000 scientists proclaimed the aim of the conference was to clarify the scientific explanation of HIV and AIDS (van der Vliet, 2004:, p.60). Disappointingly, President Mbeki opened the AIDS conference by claiming that poverty was the number one killer, and that AIDS was a disease of poverty, hence fighting poverty was more important. This caused much anger and eventually President Mbeki officially withdrew from the AIDS debate in October 2000 (van der Vliet, 2004, p.61). In a little more than a year, the President had managed to split the government and the activists and South Africa was not united in the fight against AIDS.

Pharmaceuticals and Nevirapine

Between 1997 and 2002, the South African government was involved in a legal battle with the

Pharmaceutical Manufactures' Association (PMA), after the South African parliament passed the Medicines and Related Substance Control Amendment Act (Nattrass, 2004, p.52). The act gave the government the ability to import generics produced before a patent had expired, something the PMA claimed violated the World Trade Organisation rules. The South African government refused to back down, and the standstill eventually ended up in court in March 2001 (*ibid*). TAC fought alongside the government, ultimately leading to the PMA backing down and offering to settle the case. Despite this victory, TAC and the government were still very much at opposite ends in the fight against AIDS. This clearly came to show in the PMTCT court case.

In early 2001 the South African government announced that selected hospitals would offer HIV tests to pregnant women (van der Vliet, 2004, p.75). Those who tested positive would receive Nevirapine and baby formula. The decision had not gone through parliament and was referred back to cabinet. By July 2001 nothing had been actioned so TAC instigated legal measures to force the government to provide Nevirapine (*ibid*). The government officials argued that PMTCT was still too expensive and unaffordable. However in 2001 the court decided in favour of TAC and denied an appeal in 2002 (*ibid)*. Thus forcing the government to provide Nevirapine to HIV positive pregnant women.

ARV rollout in South Africa

After the success with the fight for Nevirapine, TAC and other activist groups demanded free access to antiretroviral treatment. Even though prices had decreased dramatically, the government was still unwilling to commit to free access to ARVs based on the argument of expense, despite reports by academic researchers arguing that ARV treatment was actually affordable for the South African government (see Geffen, Nattrass & Raubenheimer, 2003; Nattrass, 2004). Furthermore despite international reactions and pressure the South African government kept their stand for over a year.

On 8 August 2003, the South African Cabinet requested the Department of Health to prepare a plan for ARV treatment (Sidley, 2003). It would become the last part of the 'National Strategic Plan for HIV and AIDS 2000-2005', which in addition addresses prevention, care and support. The Cabinet approved the plan on 19 November 2003 (Cabinet Decision 2003). Activists had

been waiting for this day for several years. It took months before the national rollout began to take place and progress has been slow in many provinces.

The ARV rollout in South Africa started in 2004 with each province having been allocated funds and developed their own systems for delivery within the national treatment guidelines (Cloete, 2005, personal comm., 30 Aug). If patients had a CD4 count of less than 200 or showed signs of being in the final stage of the disease, they qualified for ARV treatment. However, to start treatment the patient must be free of Tuberculosis (Department of Health, 2004c, p.4). The guidelines demands that patients must first receive TB medication before initiating ARVs. In addition patients must demonstrate reliability through attendance at three or more scheduled clinical visits; they must not be actively abusing alcohol or other substances; they must not have untreated active depression; patients must have disclosed their HIV status to at least one friend or family member or have joined a support group; and the patient must be able to attend regular visits at the ARV site (Department of Health, 2004c, p.3). The strict criteria for ARV treatment helped ensure that patients were ready and committed to the treatment, because ARV treatment must be taken every day for the rest of a patient's life, so adherence to the drugs is vital.

The ARV rollout has progressed in all the South African provinces, however at different paces. Some provinces like the Western Cape and Gauteng have been able to rollout ARV treatment quite successfully, while other provinces like the Eastern Cape have not managed to put enough people on ARV treatment (Maartens, 2005, personal comm., 4 Aug). The programme has successfully put over 40 000 people on ARV treatment through the public health system in one year, however the WHO estimates that over 800 000 South Africans are in need of ARV treatment (WHO, 2005). In light of this, the ARV rollout has not progressed as fast as many desired with people dying while still waiting for treatment. Despite having 44 600 people on antiretroviral treatment in March 2005 (WHO, 2005), activists were still not happy with the progress by the South African government. The health minister, Dr Manto Tshabalala-Msimang, was accused of supporting AIDS dissidents and promoting garlic, beetroot and lemon as ideal nutrient supplements for people with HIV and AIDS. Tensions are thus high between the minister and AIDS activists.

In response to the rising antenatal HIV prevalence in South Africa, Dr Manto Tshabalala-Msimang blamed the apartheid regime, which had ended more than 10 years earlier. Many of

the victims of HIV/AIDS and activists, felt that the minister was refusing to take responsibility and not taking the necessary actions to fight AIDS as illustrated below.

Figure 6 TSHABALALA-MSIMANG REFUSES TO TAKE RESPONSIBILITY AND DOES NOT TAKE THE NECESSARY ACTION TO FIGHT AIDS. (MAIL & GUARDIAN, 24 NOVEMBER 2005)

CHAPTER 2: Methodology.

The following outlines how the primary research for this dissertation was carried out, who was interviewed in the course of the research, and why exactly those individuals were of particular interest.

Until now very little has been written about the Global Fund grant in Western Cape. Due to the limited availability of literature on the topic, it was impossible to write a paper without gaining direct access to documents and reports from the various stakeholders. This involved interviewing representatives of the selected stakeholders. Through this process, in-depth knowledge was gained on the subject and used in conjunction with various opinions, assumptions, theories and models, to formulate the basis of this dissertation.

Interview Process and Case Data Collection

Formal interviews were held, in the period July – September 2005, with 11 key individuals representing; the provincial AIDS council, the provincial ARV rollout team, and other key players. This was the primary research for this dissertation.

The interviews represent qualitative research and were completed with no standard set of questions. The interviewees were encouraged to talk freely around key questions, which were uniquely developed for each interview. In order to obtain a collective view specifically regarding the success of the Western Cape rollout, all the interviewees were asked what factors they thought contributed to the success/failure of the Global Fund grant and the success/failure of the antiretroviral rollout. The responses to all these questions will be addressed in latter chapters of this research dissertation.

Selection of candidates including field experience

Key Stakeholders

Country Coordinating Mechanism (CCM)

Four representatives

Good knowledge and experience in the antiretroviral rollout.

- The sub-CCM is the body that originally submitted the grant proposal to the Global Fund, and currently is monitoring the grant. The provincial AIDS council acts as the Global Fund sub Country Coordinating Mechanism (sub-CCM) in Western Cape.

Western Cape Health Department

Four representatives

The principal recipient of the grant.

- Dr. Fareed Abdullah, in charge of the Global Fund grant and deputy director of health in the Western Cape.
- Three members of Abdullah's ARV management team and the ARV rollout. The ARV rollout team is the administrative team, which is in charge of the ARV rollout in the Western Cape. The team manages different aspects of the rollout, thus a few members were selected.
- Dr John Frankish, the Global Fund Manager in Western Cape, was interviewed twice. Dr. Frankish is solely concerned with the objectives of the Global Fund grant.

MSF and the Desmond Tutu Foundation

Two members

Partner organisations to the Western Cape Provincial Administration, (Principal recipient of the Global Fund grant).

Interview Candidates

Below is a list of the candidates interviewed for the primary research including a brief introduction to each interviewee. (A full list of members in the ARV rollout team and members of the sub-CCM can be found in the Appendix 1)

Dr Fareed Abdullah: Deputy Director General: District Health Services and Programmes: Dr Abdullah has been involved in the public health domain for a long period of time and has been instrumental in the implementation of HIV/AIDS and related programmes in the Western Cape Province. Dr Abdullah has successfully implemented the Prevention of Mother to Child Programme throughout the province. He is one of the leading figures in the fight against the spread of the AIDS epidemic in the province and represents the Department of Health on the Provincial AIDS Council.

Dr John Frankish: Western Cape Global Fund Programme Manager: Dr. Frankish has also been involved in the public health domain for a long period of time and was party to producing the grant proposal, developing the project targets and outlining the performance indicators. Dr Frankish now works as a manager for the grant and is responsible for monitoring and evaluating the progress and results of the grant. Dr. John Frankish and Dr. Fareed Abdullah were key in the research as they represented the *Principal Recipient* of the Global Fund grant.

Dr Keith Cloete: The Provincial Director for HIV/AIDS, Sexually Transmitted Infections and Tuberculosis. Western Cape Provincial Department of Health's Directorate of HIV/AIDS/TB is responsible for the ARV Programme in the Province. Dr Cloete has been working in public health in the Western Cape for many years. He has held many positions, and is currently in charge of the ARV programme in Western Cape.

Dr Nevilene Slingers: Provincial ARV Programme Manager. Dr Slingers has been working for the public health sector for many years and has held various positions. She is currently managing the dedicated ARV clinics in Western Cape. Dr Slingers is also responsible for reporting on the ARV objective of the Global Fund grant.

Ms Liezl Channing: Ms Channing works in the Western Cape Provincial Department of Health, where she is a member of the ARV rollout team. Channing is a Pharmacist and is in charge of the antiretroviral drug depot.

Dr Andrew Boulle: Dr Boulle works in the Infectious Disease Unit at University of Cape Town. He has been involved with the MSF/PAWC projects in Khayelitsha. Dr Boulle has completed much research on ART and has been involved in writing the Global Fund applications.

Dr Eric Goemaere: Head of Médecins Sans Frontières (Doctors without Borders) in South Africa. Dr Goemaere was the first person from MSF who came to South Africa to start the collaboration with the Provincial Administration of Western Cape. He has vast experience from his work with MSF and has a very good knowledge of the Khayelitsha projects.

Dr Pren Naidoo: Director of HIV/AIDS/TB in the Cape Town City Health Department. Dr. Naidoo sits on the Global Fund team and reports activities within the Cape Town City area

regarding the community based response of the Global Fund grant.

Professor Gary Maartens: Lecturer University of Cape Town: Professor Maartens is employed by the Groote Schuur Hospital in Cape Town. Professor Maartens is the Head of Infectious Diseases Unit at the Hospital and is widely regarded as the country's leading HIV clinician. The Professor has been involved in numerous HIV/AIDS research projects and is also a lecturer as well as a Physician. In the Provincial AIDS Council/sub-CCM Professor Maartens represents Clinicians.

Dr Ivan Toms: Director Cape Town City Health Department: Dr Ivan Toms founded Empiisweni SACLA Clinic. This clinic is responsible for training and supporting Community Health Workers. Dr Toms became a National Co-ordinator for Service Development in 1990 and served as a Director for a number of Health Service delivery structures. Currently he is a Director of the Cape Town City Health Department where he is responsible for Primary Health Care. In the Provincial AIDS Council/sub-CCM, Dr. Toms represents Cape Town Unicity Health Services.

Professor Robin Wood: Director of the Desmond Tutu HIV Centre, University of Cape Town. Prof Wood is in charge of the Desmond Tutu Foundation, which runs the community ARV clinic in Gugulethu. Prof Wood has extensive experience in ARVs, and acts as the Treatment Action Campaign's medical advisor. Prof Wood has provided vital research around ARV adherence.

Constraints and bias of the research dissertation

It is important to detail any potential factors that may constrain or bias of this research dissertation.

The research has been conducted without any significant constraints. Access to information and relevant people in some cases proved a long process, but in the end all key individuals were interviewed with the exception of the Treatment Action Campaign's Chairperson, Zackie Achmat, who was not available to be interviewed during the period of which this dissertation was being researched.

The fact that the research has focused on the strengths of the programme may mean that the interviewees were more likely to accept the invitation to be interviewed.

It is important to highlight the author of this research dissertation is a Norwegian, and did an 5 week internship at the Global Fund in Geneva in January 2005. This coupled with the fact that

she is a foreigner may have made it easier to get hold of information, as locals are generally more open with foreigners. Language barriers were not encountered in the research.

CHAPTER 3: Background on HIV/AIDS in Western Cape

The Western Cape is made up of a 65 % urbanised population, 3 million inhabitants in Cape Town being the largest city within the region (Abdullah, 2005, p.247). The province has 4.5 million inhabitants (*ibid*) and the lowest HIV prevalence in South Africa (Department of Health, 2005). The Western Cape is also the province with the best success rates in the South Africa's fight against HIV/AIDS (Thom, 2005). The province was the first to provide ARV medication (Goemaere, 2005, personal comm., 5 Aug), and was able to provide ARVs much quicker than any other province in South Africa (Frankish, 2005, personal comm., 22 July). This chapter discusses the background to ART within the Western Cape and provide a possible explanation for its success.

Figure 7 MAP OF THE 9 SOUTH AFRICAN PROVINCES

The Western Cape health structure is one of, if not the best, health structures in South Africa (Maartens, 2005, personal comm., 4 Aug).

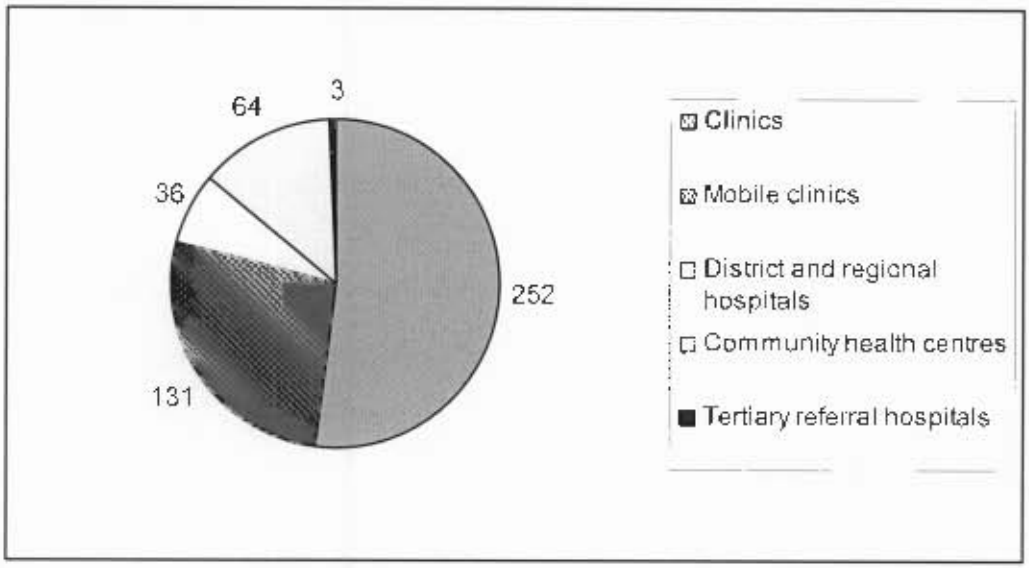


Figure 8 : Western Cape medical infrastructure source: Abdullah, 2005

The above pie chart highlights the various areas that make up this structure: 252 clinics, 131 mobile clinics, 36 district and regional hospitals, 64 community health centres, and 3 tertiary referral hospitals. There are 72.4 doctors per 100 000 population and 8 000 hospital beds (Abdullah, 2005, p.246-247). These rates are higher than in any other province in South Africa (*ibid*). Around 72% of the Western Cape population depends on the public health sector for their health care, while the other 28% have private medical insurance (Cummins, 2002, p.49).

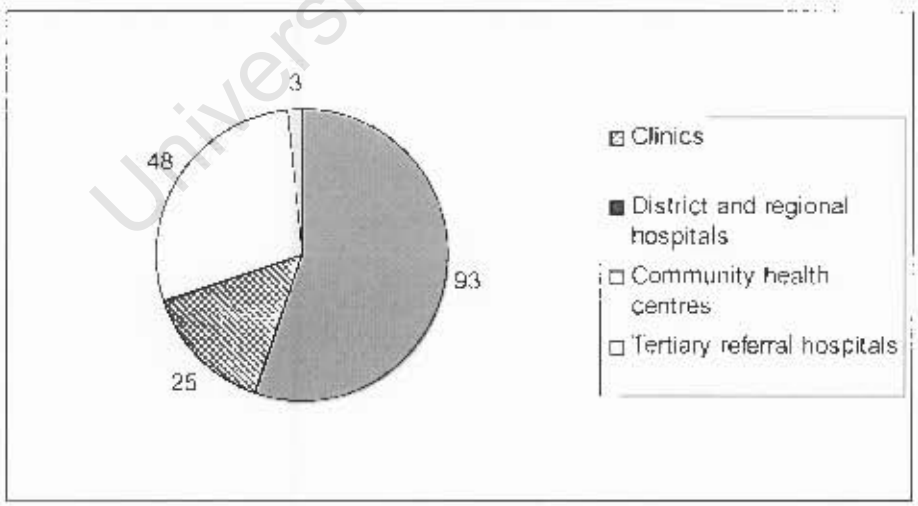


Figure 9 : Cape Town medical infrastructure, source: Abdullah, 2005

Furthermore the graph in Figure 9 outlines the 93 clinics, 48 community health centres, 25 regional hospitals and the three tertiary hospitals that are found in metropolitan Cape Town (Abdullah, 2005, p. 247). The city of Cape Town's health structure functions very well according to MSF's Eric Goemaere:

'The city ... the level of service is amazing – like the primary health care in Khayelitsha compared to other provinces.' (Goemaere, 2005, personal comm., 5 Aug)

Despite being one of the best health structures in South Africa, the Western Cape and the city of Cape Town face challenges. Despite what can be seen as good HIV/AIDS services especially when compared to Johannesburg, the Cape Town Director of Health, Dr Ivan Toms still see challenges for the health service:

'This is the data from national ... suggesting that there's a 7.4 utilization rate for under fives in the city compared to Johannesburg at 3.5, so more than double. Also our numbers of seen and seen primary health care are higher than Johannesburg, which is a similar size city. Also our TB cure rate is 70% and theirs is 57 and they've only got 16 800 TB clients and we've got 24 000. So... you know... And their condoms distributed. We get 25 condoms per adult male in the city per annum; they distribute 4.5 in Johannesburg, which is outrageous. If we just look at this I can sit back and do nothing, but I mean if we're not good enough... this is not enough condoms.' (Toms, 2005, personal comm., 23 Aug)

The Western Cape is one of the wealthiest provinces out of South Africa's 9 provinces (Cummins, 2002, p. 49). The province has a higher per capita income and higher levels of employment than the national average (Statistics South Africa, 2003).

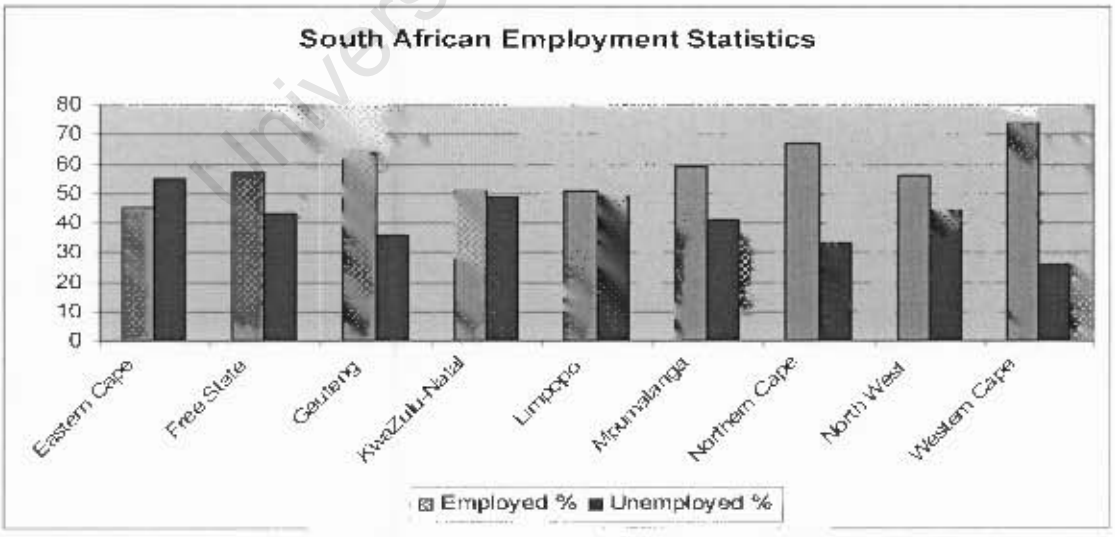


Figure 10 SOUTH AFRICAN EMPLOYMENT STATISTICS SOURCE: STATISTICS SOUTH AFRICA, 2003

In addition, the Western Cape has the highest GINI co-efficient reflecting an enormous difference between rich and poor compared to the rest of the country (Abdullah, 2005, p.247). The following statistics further highlight the environment of the Western Cape. The wealthiest 28% are mostly white South Africans, who use private medical care (Cummins, 2002, p.49). According to the 2001 census, 18% of the population in the Western Cape are white, 54% are coloured, 27% are black African and 1% are Indian/Asian (Statistics South Africa, 2003). The white and the coloured population mostly live in formal houses, while the population that lives in informal housing are mostly black Africans (Cummins, 2002, p.49), which indicates that more than 10 years after the end of the apartheid regime, wealth is still to a large degree related to skin colour.

Furthermore, the Western Cape has a high degree of chronic, non-infectious diseases including diabetes, heart disease, hypertension, asthma, arthritis, psychiatric illness and a very high rate of Tuberculosis (Abdullah, 2005, p.247). Rates of alcohol and drug abuse, violence and traffic accidents are high compared to other parts of South Africa (*ibid*). Infant and child mortality rates are lower in Western Cape than the national average, and life expectancy is higher than the national average (*ibid*). More than 25 % of the population in Western Cape are unemployed, and the poorest live in informal housing in urban areas (Cummins, 2002, p.49). In some of the informal housing areas in Cape Town violence is common, and homicide is the biggest cause of death in men (followed by HIV/AIDS) (MRC *et al*, 2005l).

HIV prevalence by province among antenatal clinic attendees, South Africa: 2002 – 2004

Province	2002	2003	2004
KwaZulu-Natal	36,5	37,5	40,7
Gauteng	31,6	29,6	33,1
Mpumalanga	28,6	32,6	30,8
Free State	28,8	30,1	29,5
Eastern Cape	23,6	27,1	28,0
North West	26,2	29,9	26,7
Limpopo	15,6	17,5	19,3
Northern Cape	15,1	16,7	17,6
Western Cape	12,4	13,1	15,4
South Africa	**26,5**	**27,9**	**29,5**

(Adapted from Department of Health, 2005).

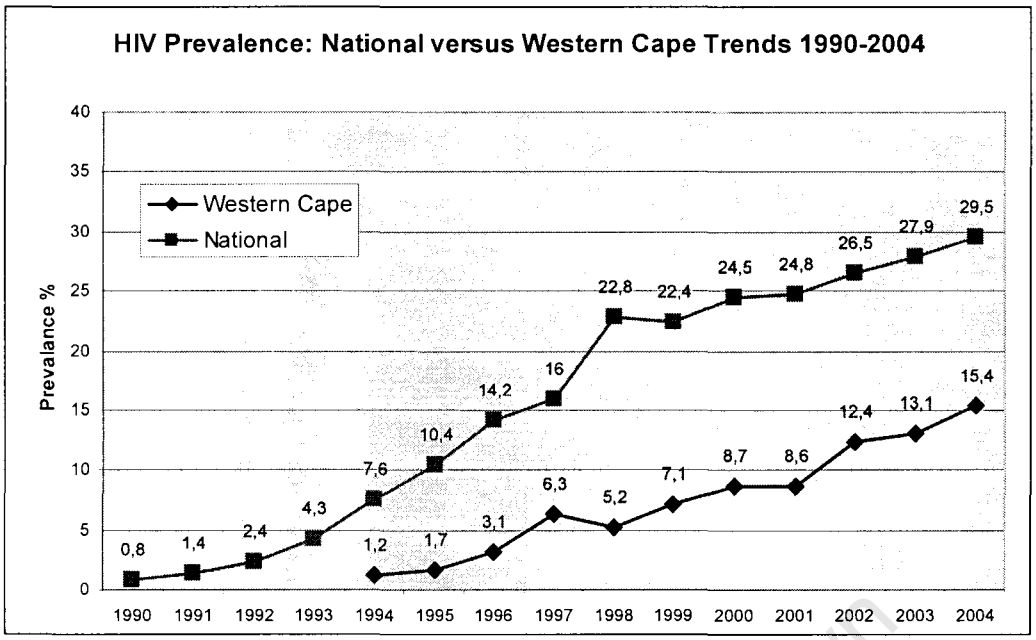


Figure 11 ESTIMATED HIV PREVALENCE RATES ADAPTED FROM PAWC, 2005A AND DEPARTMENT OF HEALTH, 2005

As can be viewed above the HIV prevalence in Western Cape (15,4 %) is lower than any other province and lower than the national average (29,5 %). Note however that the HIV/AIDS epidemic still affects an increasing number of people in the Western Cape (PAWC, 2005a). The situation is expected to worsen as antenatal prevalence continues to rise steadily every year. HIV prevalence in the Western Cape rose from 1.2% in 1994 to 15.4% in 2004 (PAWC, 2005a). This number masks the huge disparities between different areas in the province such as Khayelitsha and Blaauwberg where the HIV antenatal prevalence rates are as high as 33% (Khayelitsha) and as low as 1.2% (Blaauwberg) (PAWC, 2005a). The Western Cape has thus several epidemics growing at different speeds within the province. Never the less, HIV/AIDS prevalence has been increasing steadily for over ten years, and is expected to continue to rise for the next years (Abdullah, 2005, personal comm., 23 Sept). Although it is not the largest single cause of mortality, apart from among children and women aged 15-49, the HIV epidemic is by many still believed to be the single largest health crisis facing the Western Cape at the present time (Abdullah, 2005, p.248).

Prevention of mother-to-child transmission of HIV

As discussed above, HIV prevalence rose steadily from 1990 in South Africa. Although antiretroviral treatment were available for HIV positive who had private health care from

1996/7 it took many years for it to be available in the public health system (Wood, 2005, personal comm., 9 Sept). Antiretrovirals were seen as too expensive for a public health system, and many questions were raised around their effectiveness. In spite of this the Western Cape started the first provincial government-run project to prevent mother-to-child-transmission (PMTCT) of HIV in South Africa in 1999 (Slingers, 2005, personal comm., 1 Sept). In an interview Dr. Eric Goemeare quoted the project was secretly carried out at the time:

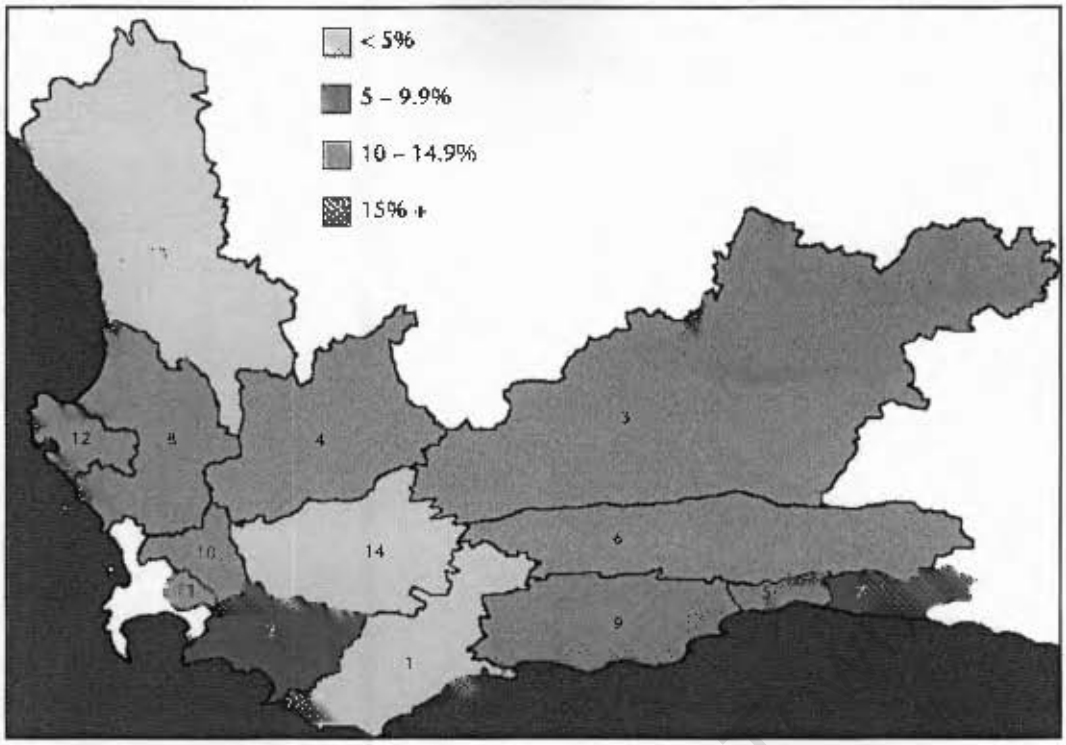
"They had started PMTCT. They wanted to start a program very low key because they didn't want the national to know about it. They had taken the initiative; the province has a lot of autonomy." (Goemaere, 2005, personal comm., 5 Aug)

From January 1999 PMTCT was made available to HIV positive pregnant women in Khayelitsha[3], The Health Department of the Provincial Administration Western Cape (PAWC) started the PMTCT programme in two midwife obstetric units in Khayelitsha (Abdullah, 2005, p. 249). In 1999, the antenatal prevalence in Khayelitsha was standing at 20%, and at the time it was widely accepted that PMTCT could dramatically reduce the chances of HIV transmission (Goemaere, 2005, personal comm., 5 Aug). In the initial Khayelitsha PMTCT programme, AZT monotherapy was provided to HIV-positive pregnant women. Previously 3 out of 10 pregnant women would normally transmit their HIV infection to the child either during pregnancy, at birth or while breastfeeding (Abdullah, 2005, p. 249). In 1999 AZT was reducing the risk of transmission of HIV from mother to child by about 50 per cent (*ibid*).

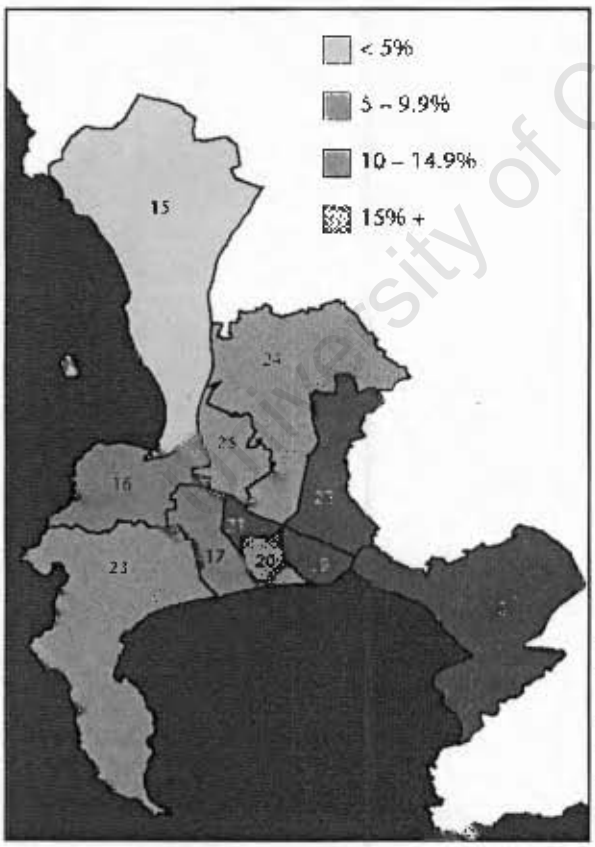
[3] Khayelitsha is a poor township 30km outside of central Cape Town. It has more than 500 000 residents with more than half of the adult population unemployed, and most living in informal housing (shacks).

HIV Prevalence by Health District: Western Cape 2000 – 2004					
District	HIV PREVALENCE %				
	2000	2001	2002	2003	2004
Blaauwberg		0,6	8,2	4,4	1,2
Cape Town Central		3,7	11,9	11,6	13,7
Greater Athlone		6,8	8,9	10,1	16,4
Helderberg		19,0	19,1	19,1	18,8
Khayelitsha		**22,0**	**24,9**	**27,2**	**33**
Mitchells Plain	5,4	0,7	4,0	6,3	12,9
Gugulethu/Nyanga		**16,1**	**27,8**	**28,1**	**29,1**
Oostenberg		5,7	14,5	16,1	14,8
South Peninsula		5,9	6,0	9,3	10,8
Tygerberg Eastern	5,1	6,1	10,4	7,9	12,7
Tygerberg Western		7,9	12,7	8,1	15,1
Bredasdorp/Swellendam		1,4	3,2	1,1	10
Caledon/Hermanus		13	10,8	14,4	12,5
Ceres/Tulbagh		6,2	9,4	7,5	10,5
Worcester/Robertson	3,2	5,7	4,5	3,9	8,4
Mamesbury		2,7	6,7	10,7	6,2
Paarl	4,5	8,3	11,4	10,1	8,9
Stellenbosch		7,1	8,5	8,5	17,8
Vredenburg		8,9	9,0	10,0	13
Vredendal		1,3	10,2	3,9	5,8
Knysna/Plettenberg Bay		13,3	15,9	15,6	17,4
Klein Karoo		0,8	7,8	5,4	5,5
Mossel Bay/Langeberg		7,0	6,8	13,3	12,5
George	5,6	10,0	10,0	11,6	13,3
Central Karoo		5,5	7,4	6,5	8,9

Figure 12 ESTIMATED HIV PREVALENCE BY HEALTH DISTRICT: WESTERN CAPE 2000–2004 ADAPTED FROM PAWC, 2005A



8.2. HIV Prevalence: Metropole Districts 2003



1. Bredasdorp/Swellendam
2. Caledon/Hermanus
3. Central Karoo
4. Ceres/Tulbach
5. George
6. Klein Karoo
7. Knysna/Plettenberg Bay
8. Malmesbury
9. Mosselbay/Langeberg
10. Paarl
11. Stellenbosch
12. Vredenberg
13. Vredendal
14. Worcester/Robertson
15. Blaauberg
16. Cape Town Central
17. Greater Athlone
18. Helderberg
19. Khayelitsha
20. Mitchell's Plain
21. Nyanga/Gugulethu
22. Oosterberg
23. South Peninsula
24. Tygerberg Eastern
25. Tygerberg Western

Figure 13 The maps illustrate HIV prevalence in Western Cape in 2003 (Source: PAWC, 2004a)

In addition to providing AZT to HIV-positive pregnant women, PAWC set up a voluntary counselling and (VCT) testing service at two maternity units. Follow-up care for the mother and the baby were set up at nine clinics in the area to provide advice to mothers about formula feeding (or exclusive breastfeeding) (Abdullah, 2005, p. 249). This was important as it ensured the follow-up checks on babies could be conducted to monitor for clinical signs of HIV where HIV could be definitively tested between the age of nine and 18 months (*ibid*). Previously in 1998, there were only 450 HIV tests in Khayelitsha, but with the expansion of the VCT service 22 000 HIV tests are now taken per year (2005) (Goemaere, 2005, personal comm., 5 Aug).

The international non-governmental organisation (NGO), Médecins Sans Frontières (MSF) (In English known as 'Doctors without Borders'), began supporting the Khayelitsha PMTCT programme in 1999. This created the foundation of a partnership between MSF and PAWC. MSF wanted to start a project in South Africa for three reasons (Goemaere, 2005, personal comm., 5 Aug).

- Firstly, Durban 2000, the first international AIDS conference, would be conducted in South Africa and MSF was particularly interested in introducing issues around access to antiretroviral treatment at the conference.
- Secondly, South Africa was, according to UNAIDS, the country with the highest number of people living with HIV/AIDS.
- Thirdly, MSF perceived South Africa as being the country that was highly devoted in the fight against drug patents.

MSF considered starting a programme in Alexandra Township (a township on the edge of Sandton, Johannesburg). However, neither officials in Alexandra nor the national government was interested in a program involving the use of antiretrovirals. Dr Eric Goemaere explains how, by chance, he came to discover the PMTCT programme in Khayelitsha:

"In that time nobody suspected that there was a problem with antiretrovirals in this country. On the contrary there was a famous court case against pharmaceutical company, – to have access to generics. As a matter of fact, we discovered afterwards that anti-retrovirals were never part of the fight. It was for all the types of contracts, the essential contracts, – it was the first time in two years that the anti-retroviral were not part of the national protocol. I bought a ticket to go back to Europe, where I was prepared to say, 'well, sorry, we made a mistake'. But by chance I knew Zackie, the head of TAC, by email, I had never met him, but bought a ticket to say hello and have a chat with him. And Zackie is the one who told me "you know I think they

started something in Khayelitsha but I'm not totally sure, it looks like it's a rumour..." so we came here, the next day to discover that they had started something in maternity... They had started PMTCT. They wanted to start a program very low key because they didn't want the national to know about it. They had taken the initiative; you know the province has a lot of autonomy. And I came that day, discovered this programme, and I never left. That is what I've been doing. And that's the reason why Khayelitsha, it's the reason we came here. Since they developed the program..." (Goemaere, 2005, personal comm., 5 Aug)

The partnership with MSF allowed the PAWC to carry out pilot research before applying PMTCT through out the province. It was at times difficult, particularly when the national government was opposed to the use of antiretrovirals. PAWC and MSF gained great experience in the provision of antiretrovirals in a resource limited environment, showing that the reduction in mother-to-child-transmission (MTCT) was effective even in poor communities (MSF *et al*, 2003). From 2001, the PMTCT programme expanded to more than 300 antenatal and child health clinics in the Western Cape (Abdullah, 2005, p.249), and further research into the programme for HIV positive pregnant women resulted in a more effective prevention. Pregnant women and their babies in Western Cape after 2003, received more effective dual therapy (AZT + Nevirapine) (*ibid*),with infants being tested at 14 weeks and HIV positive infants being then referred for long-term antiretroviral treatment. In 2002, the transmission rate, using AZT monotherapy, was recorded at 8.9 per cent. Two years later, the results from HIV tests on babies born from HIV positive mothers who received dual therapy, showed a decrease in the transmission rate down to 5.5 per cent (*ibid*). In 2005 pregnant women with a CD4 count of less than 200 were referred, and fast-tracked for antiretroviral treatment during and after their pregnancy (Abdullah, 2005, personal comm., 23 Sept). Those women with CD4 counts above 200 received AZT from 28 weeks pregnancy, AZT and Nevirapine in labour and Combivir for seven days after the baby is born (Abdullah, 2005, p.250). The infant was given one dose of Nevirapine and AZT syrup for seven days and the mother formula fed the baby. This combination has reduced HIV transmission rates down to below 2 per cent for the Western Cape (Toms, 2005, personal comm., 23 Aug).

Pilot ARV projects

In April 2000 the Provincial Administration of the Western Cape and MSF set up three HIV/AIDS dedicated clinics within Khayelitsha's primary health care centres (Kasper et al, 2003). These clinics were dedicated to offer treatment to the mothers and their infected children. By May 2001, the HIV/AIDS clinics began to offer ARV treatment to people with an advanced

stage of HIV infection (Goemaere, 2005, personal comm., 5 Aug). The treatment project was initiated to demonstrate that it was feasible and repeatable to treat HIV/AIDS with antiretroviral (ARV) drugs in a primary health care setting and in a resource-limited environment (Goemaere, 2005, personal comm., 5 Aug).

By introducing the treatment project it aimed to prove that developing countries could provide affordable HIV/AIDS care with low-cost ARV drugs (Goemaere, 2005, personal comm., 5 Aug). The three clinics: Site B Khayelitsha, Site C Nolungile and Michael Mapongwana, are located within community health centres in Khayelitsha. They provide other HIV/AIDS services along with ARV treatment, such as counselling, support, prophylaxis and treatment of opportunistic infections (PAWC *et al*, 2005). The programme was initially almost exclusively run by MSF; however in recent years the PAWC has started gradually to take over (Slingers, 2005, personal comm., 1 Sept). The Western Cape will take over the clinics fully in 2007 (Rosenberg, 2005a). The clinics account for a proportionally large share of people on antiretroviral treatment in the Western Cape (Abdullah, 2005, personal comm., 20 July). In July 2005, more than 2400 patients were on antiretroviral treatment at these three sites, about ¼ of the total number of people on ARV treatment in the Western Cape (Cloete, 2005, personal comm., 30 Aug).

MSF has had a good relationship with the Infectious Disease Epidemiology Unit at the University of Cape Towns, which has produced much research about the results and successes of the MSF programme (Goemaere, 2005, personal comm., 5 Aug). Key progress in disclosure, adherence and improved quality of life made the MSF programme a well known successes (Goemaere, 2005, personal comm., 5 Aug). An increasing number of HIV tests were preformed in Khayelitsha; in 2004 there were 20 times more tests than in 1998. During 2004, 20 000 HIV tests were performed; 25 % more tests than in 2003 (PAWC *et al*, 2005). This figure indicates that 10% of the sexually active population in Khayelitsha had an HIV test in 2004 (*ibid*). The three MSF clinics have also become more popular, with more consultations taking place as a result of more staff capacity. In 2004 over 40 000 consultations took place (*ibid*). The majority of the patients who started ARV treatment were women (70%) (Coetzee *et al*, 2004a). The MSF programme has also been able to increase the CD4 count of the average patient. In 2002 the median CD4 count of each patient starting ARV treatment was a low 42 (MSF *et al*, 2003). In 2004 it had increased to 85 (PAWC *et al*, 2005), indicating that patients

were healthier when starting ARV treatment. ARV patients who were more open around disclosure to their partners were believed to have improved quality of life (Coetzee and Nattrass, 2004, p.5). Patients were also more open and willing to disclose their HIV status and research found that 72.6% had disclosed to a support group, while 82% had disclosed to one or more family member (Coetzee and Nattrass, 2004, p.4). Stigma attached to HIV/AIDS is also believed to have declined drastically since 1999 (Goemaere, 2005, personal comm., 5 Aug). In addition research has clearly proved that providing ARVs in the poor township were highly possible (Kasper *et al*, 2003).

Shortly after the introduction of the three MSF ARV clinics, the Desmond Tutu Foundation set up a clinic in Gugulethu (Wood, 2005, personal comm., 9 Sept). The foundation, like MSF, carried out vital research for PAWC (Cloete, 2005, personal comm., 30 Aug), proving that people in limited resources communities could access ART, and that they could have as high adherence to the ARV drugs as people in the developed countries (Orell *et al*, 2003).

PAWC entered into partnerships with at least six other NGO or research-based initiatives in public health facilities within the Western Cape (Cloete, 2005, personal comm., 30 Aug). By the end of 2003 the Western Cape Province had established ARV sites in Langa, at the G F Jooste, Groote Schuur, Tygerberg and Red Cross Hospitals in addition to the Gugulethu clinic and the three Khayelitsha clinics (Abdullah, 2005, p.250).

CHAPTER 4: The Global Fund to fight AIDS, Tuberculosis and Malaria

This research dissertation has so far discussed the exploration and existence of HIV/AIDS, HIV/AIDS policies within South Africa and the development / and prevention of HIV/AIDS particularly in the Western Cape. The following chapter introduces the purpose and structures of the Global Fund to fight AIDS, Tuberculosis and Malaria.

AIDS, Tuberculosis and Malaria kill over 6 million people each year (Global Fund, 2005d). Without access to effective treatment and prevention, the numbers of people dying from these diseases are expected to rise dramatically. AIDS alone could kill more than 40 million people (UNAIDS, 2005). With the arrival of cheaper antiretrovirals many of these 40 million could live a normal life. The Global Fund was created to finance this striking turn-around in the fight against AIDS, TB and Malaria (Global Fund, 2005d). This chapter will focus on the Global Fund, and provide an understanding of how the fund operates.

International agitation with the high numbers of deaths from AIDS, TB and Malaria started to accumulate in the new millennium. The Global Fund was set up to fight these diseases, and, following a call by United Nations Secretary-General Kofi Annan and others, to create a global health fund to increase dramatically the available funding to fight AIDS, TB and Malaria (UN, 2001). The initial donor capital was pledged in May 2001, with both private and public stakeholders recommending the fund give out grants on the basis of received proposals (Global Fund, 2005e). The Global Fund to Fight AIDS, Tuberculosis and Malaria was constituted as an independent Swiss foundation in January 2002 and the Fund was fully operational by 2003 (*ibid*). The first round of proposals, Round One, committed funding to 55 programmes in 36 countries (Global Fund, 2005c). Since the first round of grants, there have been four succeeding rounds with round five in September 2005 being the most recent. To date, the Global Fund has committed US$ 4.4 billion in 128 countries to support the fight against AIDS, TB and Malaria (Global Fund, 2005d)[4].

According to the Global Fund 2004 Annual Report, seven key structures shape the Global

[4] Figure taken on 21 November 2005 from the Global Fund's website www.theglobalfund.org for accurate figures please console with this website.

Fund: the Board, the Secretariat, the Technical Review Panel, Country Coordinating Mechanisms, Principal Recipients, Local Fund Agents and the Partnership Forum (Global Fund, 2005a).

The members of the Global Fund's Board consist of representatives from donor and recipient governments, non-governmental organizations, the private sector and affected communities. Representatives of the World Health Organization, UNAIDS, and the World Bank are also represented at Board meetings but without voting rights (Global Fund, 2005a). The Chair of the Board is United States Secretary of Health and Human Services Tommy G. Thompson, and the Vice-Chair is Dr Hélène Rossert-Blavier, Director-General of the French non-governmental organization AIDES (*ibid*).[5] A full list of current board members is found as an annexure.

The Global Fund's Secretariat conducts all the day-to-day operations of the Global Fund. Approximately 120 professional and administrative personnel, whose main responsibilities include mobilising resources, managing grants and monitoring performance, staff it. The Secretariat is based in Geneva, Switzerland and its Executive Director is Dr. Richard Feachem (Global Fund, 2005a).

When a country decides to apply for funding from the Global Fund, several key steps must be taken (Global Fund, 2005a):

- Firstly, the grant proposal must be submitted via a multisectoral Country Coordinating Mechanism (CCM).
- Secondly, a multisectoral CCM should have representatives from public and private sectors, including government, non-governmental and faith-based organisations, people living with AIDS, TB or Malaria, bilateral and multilateral development agencies, and academic institutions.
- Thirdly, a country can have a national CCM as well as it could have regional sub-CCMs. This is the case in South Africa, where the national AIDS council acts as the national CCM, while the provincial AIDS council acts as the sub-CCM. In such cases the grant proposal must first be submitted from the sub-CCM and then to the national CCM, which submits the proposal directly to the Global Fund.

[5] For a full understanding of the make up of the Global Fund's board please consult www.theglobalfund.org

- Finally, the grant proposal should be in line with national strategies and stakeholders' different priorities. The goal is for the CCMs to have identified lack of funding for an area, which can be funded by the Global Fund.

When the proposal arrives at the Global Fund it gets submitted to The Technical Review Panel (TRP), which is an independent body of international AIDS, TB and Malaria experts and health and development experts (Global Fund, 2005a).[6] The TRP assesses the grant proposal for technical and scientific value based on global best practices. The TRP meets to review the proposals submitted for each funding round prior to the Board's meeting regarding the decision of which grants get funding. In fact, the TRP recommends to the Board proposals that are qualified for funding, which the Board either endorses or rejects. If the proposal is successful the Board initially commits funding for the full 5 years, however only funding for the first two years (phase one) is allocated. The board waits until the grant reaches phase two, before it funds years three to five (Global Fund, 2005b).

After the Board's approval, the secretariat and the Principal Recipient (PR), who will receive the grant, engage in negotiations to determine the exact amount of the grant, set different performance indicators and targets, and decide on which conditions will have to be met before the two year grant agreement is signed (Global Fund, 2005a). Finally, the grant agreement is signed and the PR receives the funds to start the programme. The PR is now legally responsible for the programmes results, monitoring, evaluation, and financial accountability. The CCM oversees the implementation of the grant, reviews reports of the PR, and ensures local ownership.

At milestones specified in the agreement, the PR sends a disbursements request to the Global Fund. In this disbursement request, the PR needs to demonstrate how the money has been spent and what targets have been reached. This usually is demonstrated by a six-month progress report. An independent agent (Local Fund Agent) then verifies the request (Global Fund, 2005a). This represents the foundation for the Global Fund's system of performance-based funding.

Since the Global Fund has no staff outside its Secretariat in Geneva it has no way of verifying grant performance other than what is reported by the Principal Recipient. The Local Fund Agent

[6] A list of TRP members can be found in the Global Fund's 2004 Annual Report, available at www.theglobalfund.org

(LFA) is an independent agent, which is contracted by the Global Fund to assess the grant performance in a country (Global Fund, 2005a). The Global Fund contracts one LFA for each recipient country to assess the capacity of a PR to manage and administer the grant, manage the implementation of the funded programs and report on financial and programmatic progress. The LFA also verifies all disbursement requests, progress updates and reviews annual audit reports.

The Global Fund 2004 Annual Report list the following agents contracted to operate as LFAs: Chemonics International Inc., Crown Agents for Overseas Governments and Administrations Ltd., Deloitte Touche Tohmatsu Emerging Markets Group, KPMG International, Pricewaterhouse Coopers, the Swiss Tropical Institute of Chad and the United Nations Office for Project Services (Global Fund, 2005a). In South Africa, KPMG International serves as the LFA (Global Fund, 2006).

Grant Performance

Grant performance represents the cornerstone of the Global Fund's business model (Global Fund, 2005b). It is based on the principle that it will only fund programs that successfully contribute to the treatment and prevention of HIV/AIDS, TB and Malaria. The performance-based funding covers all aspects of the Global Fund grant process, including proposal development, grant agreements, regular disbursements and Phase Two evaluations (*ibid*). For the measurement of program success, all grant agreements include indicators and targets consented upon by the Principal Recipient and by the Global Fund. This is to ensure that the funding allocated to areas that are being managed and spent effectively.

As mentioned earlier, the Global Fund generally approves grant proposals covering a five-year period. Grants are initially committed for the first two years of the proposal period. Continued funding to cover the remainder of the proposal period depends on satisfactory program performance and the availability of resources. The remainder of the grant covering years three to five is referred to as 'Phase Two' (Global Fund, 2005b). The Global Fund uses 'Phase Two' as a kind of checkpoint. Only grants with satisfactory performance measured against agreed targets for the first two years of the grant's life will continue to receive funding for the remaining three years (*ibid*). The Phase Two process was initiated in February 2004 for the first of the grants from round one (Global Fund, 2005a). All grants that approach their two year mark need to submit a phase two application, where they have the opportunity of changing

targets and indicators, renegotiate the grant agreement (Global Fund, 2005b). With the arrival of the 'Phase Two' money comes another grant agreement with the Global Fund. Since the Phase two process is the renewal process of grants, grant performance decides further funding (*ibid*).

Global Fund grants in South Africa

Since the establishment of the Global Fund to fight AIDS, TB and Malaria as a financial institution, it has given out US$ 4.4 billion to 128 countries (Global Fund, 2005d) There have been five funding cycles, the first in 2003 and the most recent in September 2005. South Africa has received five grants from the Global Fund, three were from the first round of grants, 'Round One', one from 'Round Two', and one from the third round of grants, 'Round Three'(Global Fund, 2006).

A grant's life span is determined from the date the grant agreement is signed, and in the case of South Africa, the three grants from round one were signed August 8 2003, while the grant from 'Round Three' was signed August 25 2004 (Global Fund, 2006). This means, the three grants given to South Africa from 'round one' were at their 'Phase Two' renewal point in the year 2005. All three grants were initially declined for 'Phase Two' funding, however two of the grants are still in review, and their fate as of January 2006 uncertain. The grant from round two was signed on November 15 2005 (Global Fund, 2006). The five grants bear the following titles:

1. **Round One:** 'Strengthening national capacity for treatment, care and support related to HIV and TB, building on successful behaviour change initiatives in South Africa (**Soul City**)'.
2. **Round One:** 'Strengthening national capacity for treatment, care and support related to HIV and TB, building on successful behaviour change initiatives in South Africa (**loveLife**)' (only funded for the first two year, denied funding for the remaining three years).
3. **Round One:** 'Enhancing the Care of HIV/AIDS infected and affected patients in resource-constrained settings in **KwaZulu-Natal**'.
4. **Round Two:** 'Strengthening **National and Provincial** Capacity for Prevention, Treatment, Care and Support Related to HIV and Tuberculosis'.

5. **Round Three:** 'Strengthening and expanding the **Western Cape** HIV/AIDS prevention, treatment and care programmes'.

The South Africa's AIDS council acts as the Global Fund's South African Country Coordinating Mechanism (CCM) with the Deputy President and the Minister of Health as chairs (Global Fund, 2006). South Africa has requested $183,814,240.00 from the Global Fund. So far only $70,903,651.00 has been approved for the fist period of the grants (Phase One) (*ibid*). Further funding will depend on satisfactory performance in the 'Phase Two' review, and therefore only $55,350,967.00 has been disbursed by January 2006 (*ibid*). If additional grants are declined for 'Phase Two' funding the total amount over the five year period will be drastically reduced.

A turbulent relationship with the Global Fund

The grants to 'Soul City' and 'LoveLife', as classified above were completed without incident. However from the year 2002 to 2003 grant number three, the grant given to KwaZulu Natal, resulted in a stand off between the South African government and the Global Fund's secretariat.

The cause of the stand off was due to the fact that KwaZulu Natal had applied for funding from the Global Fund, without consulting the national government (Cullinan, 2003). The province had formed a sub-CCM, which had endorsed the proposal and submitted it to the Global Fund without consulting it with the national CCM. Note however, at the time that KwaZulu-Natal's application was submitted, there was no existing national CCM (Thom, 2003). Later, the government declared that the South African National AIDS Council (SANAC) would act as the national CCM (Cullinan, 2002) By that time, the KwaZulu-Natal application had already been submitted– Note this application was supported by the KwaZulu-Natal sub-CCM consisting of the provincial government, the Durban Chamber of Commerce and Industry, non-governmental organisations and AIDS researchers – (Thom, 2003). The Global Fund had accepted the proposal, and the grant project was due to receive funding in the first round of grants (Thom, 2003). Only after the grant had been accepted did the national CCM members, in particular the Minister of Health, Dr. M Tshabalala-Msimang, become aware of the multi million dollar grant that had been awarded to KwaZulu Natal (Cullinan, 2003; Jubasi, 2003).

At this time the minister did not want to not accept the funding (Cullinan, 2003). The

KwaZulu-Natal story caused much unrest within the South African AIDS activist community, with the Treatment Action Campaign (TAC) threatening legal action. There were many articles written in the media about this matter. Some argued that constitutionally, health care is a concurrent function of national and provincial government; therefore legally, KwaZulu-Natal should be able to raise money to fund its own priorities.

This controversy resulted in a one-year delay for the grant, and eventually, in August 2003 all three grant agreements from 'Round One' to South Africa were signed were signed by the relevant parties (Global Fund, 2006), clearing the way for a successful application from the Western Cape.

CHAPTER 5: Grant SAF-304-G04-H - 'Strengthening and expanding the Western Cape HIV/AIDS prevention, treatment and care programmes'

The Western Cape Department of Health has been highly committed to HIV/AIDS prevention, treatment and care at times when the national government was filled with scepticism. In particular when the government was claiming ARVs to be toxic and were opposed to universal treatment. The Western Cape Province wanted to expand access to antiretroviral treatment, however with no support from governmental funds PAWC was forced to look for external funding. The province submitted its first proposal to the Global Fund in 'Round Two' but the grant was unsuccessful (Boulle, 2005, personal comm., 10 Aug). At the time of this application there was massive conflict between the national government, the health minister, Dr. Manto Tshabalala-Msimang, and the Global Fund Secretariat surrounding the KwaZulu-Natal grant. Dr. Andrew Boulle, who was involved in writing the 'Round Two' application, explains why he thought the proposal failed to get funding:

'I think there were actually seventeen South African proposals in that round, and because the South African CCM didn't follow procedure, they were all rejected on that. ... The process was always political. The reason we all knew why 'Round Two' hadn't been considered was because of the relationship between the South African CCM and the Fund... and I think that the Fund was very encouraging to resubmit'(Boulle, 2005, personal comm., 10 Aug).

Dr Boulle suggests that the Western Cape knew that the proposal was rejected on political grounds, and on the encouragement from Dr Richard Feachem, the executive director of the Global Fund, they improved and resubmitted the proposal. Coincidently Dr Feachem was in South Africa in April 2003 to meet with the South African Government to solve the issue around KwaZulu Natal with the aim to agree on and sign the grant agreement (Goemaere, 2005, personal comm., 5 Aug), so that the programme could start running. Despite Dr Feachem's hope to resolve the KwaZulu Natal story, the issue remained unsolved (Cullinan, 2003). By this time the MSF/PAWC project in Khayelitsha already was up and running, and according to Dr Eric Goemaere, it sparked Dr Feachem's interest:

'Khayelitsha becoming a well-known programme, mainly after the publication by WHO, they did a sort of best practice series, and Khayelitsha was one of the first to be published. So Feachem was interested to come for a visit, and asked for a visit. So he was invited here and I think he was impressed by the program and it's very interesting, you know Fareed used MSF

against the national, and I'm sure Feachem used the Western Cape against national. It was very well known that he was going from one province to another. No the matter of fact, when he came to visit here he came to South Africa to sort out the KwaZulu Natal story ... he told me that he thought this is a misunderstanding, let's take a ticket – flight ticket and spend three days talking face to face with people, it must be, it's not possible, it's a misunderstanding and we saw Richard Feachem here absolutely, absolutely... he was furious. He had lost four days of his life for nothing – you know. In fact, he didn't realize that South Africa, that it was such a mission and that he hasn't achieved anything since then because it was being blocked so he was so pleased to find here Fareed and the whole team that was ready and keen to start something and he needed something that was already working you know.' (Goemaere, 2005, personal comm., 5 Aug)

The effort of work that went into this second application was impressive; it was a much more inclusive and holistic proposal, involving a number of NGOs.

'And honestly today I have never seen a public administration working like the way they work. I was called there 10 o'clock at night because they have to finalize the papers and those guys were working 'til 12 o' clock at night. I mean the public, civil servants? Not in that many places, and that is fantastic, you know?' (Goemaere, 2005, personal comm., 5 Aug)

In May 2003, the Western Cape Provincial Department of Health applied for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (PAWC, 2003a). The application was successful and the grant was approved on the Global Fund's sixth Board Meeting - Chiang Mai, Thailand, 15-17 October 2003 (Global Fund, 2005f). This initiated the grant negotiations with the secretariat with the final grant agreement being signed on 25 August 2004 (Global Fund, 2006). The arrival of the first disbursement of funds came a little time later and on October 20 2004 the Western Cape Premier, Marthinus van Schalkwyk, announced the breakthrough for the province. The Western Cape Provincial Department of Health had received the biggest grant so far given to a provincial department (PAWC, 2003c). The grant by the Global Fund was a five-year programme to strengthen and expand the province's comprehensive HIV/AIDS programme, with a total value of the five-year grant programme of US$66,5 million.

The five year programme is divided into four objectives:

1. To strengthen the ARV treatment programme through the expansion of the provision of antiretroviral treatment, providing for ARV treatment in Phase One of the Grant at six of the planned 45 ARV treatment sites in the province.

2. To strengthen the current prevention effort by expanding a peer education programme among youth at secondary schools.

3. To strengthen palliative in-patient and home-based care services by expanding the already existing network of hospice facilities and their linked home-based care services.

4. To strengthen community-based responses to the epidemic through the development and implementation of local support projects within specified focus areas.

(Global Fund M&E Plan, Western Cape Department of Health 2004d)

Each of the four areas were divided as follows and comprised of a total value of USD 15,509,356 for the first two years:

The four objectives of the Global Fund grant:	**Year 1 (USD)**	**Year 2 (USD)**	**Total (USD)**
ARV Treatment / Operational Research	3,560,083	5,607,623	**9,167,706**
Peer Education	876,928	932,653	**1,809,581**
Palliative Care	858,857	1,586,429	**2,445,286**
Community-Based Response	866,714	1,220,069	**2,086,783**
Total	**6,162,582**	**9,346,774**	**15,509,356**

Figure 14 The four objectives of the Global Fund grant (Adapted from the Global Fund Work Plan, Western Cape Department of Health, 2004c)

The first objective: antiretroviral treatment received almost 2/3 of the total grant. It has therefore been the main focus of this dissertation. To further understand this objective it is important to note that the ARV treatment component in the grant agreement was split into five main areas:

1. Staff and administration
2. IT infrastructure
3. Recourse centre
4. ARV Drugs
5. ARV treatment

For the purposes of this dissertation the latter two components are discussed further below.

ARV drugs

The Western Cape is fortunate to have a comparatively well functioning health sector, however the medical depot in Western Cape came under scrutiny by KPMG, the Local Fund Agent,

before the grant agreement with the Global Fund was signed (Abdullah, 2005, personal comm., 19 July). KPMG had previously completed an audit of the medical depot, and demanded changes. The solution was to set up a new, separate medical depot for antiretrovirals (Abdullah, 2005, personal comm., 19 July). This provided a quick short-term solution to the problem, while the long term solution would be to improve the existing depot. The PAWC set up an ARV depot in six weeks, which was enough time to satisfy KPMG and get the grant agreement signed (Abdullah, 2005, personal comm., 19 July).

The ARV depot to this day functions very well, and has never had any major stock shortages on ARVs (Channing, 2005, personal comm., 25 Aug). It is important to note that the Western Cape is fortunate in having local suppliers, which enables them to purchase antiretroviral drugs monthly (Channing, 2005, personal comm., 25 Aug). The depot keeps three to four months of stock, which has a value of R7, 5 to R10 million (Channing, 2005, personal comm., 25 Aug).

The easy access to ARVs for clinics has insured that the sites never run out of ARVs, while the same cannot be said about the general medical depot. Eric Goemaere, who runs the MSF programme in South Africa, very much appreciates the ARV depot (Managed by Liezl Channing).

"We have a straight management line with direct contact to one person to whom to decide... and if you have a problem, then Liezl (Channing) is available – there's no drugs or the drug's gone. Because other times you have to go via, via, via, and you don't get an answer there for four weeks, that's for sure. It makes a huge difference" (Goemaere, 2005, personal comm., 5 Aug)

There is no question that the specialised ARV depot has contributed to the success rate of the Global Fund grant. One can always question the solution as a short-term solution which has been highly criticised by some who claim that the resources should have been used to strengthen the functioning of the general Cape Medical Depot that houses all other medicines and diagnostics procured by the Department of Health, instead of unnecessarily building a new infrastructure, hiring new staff and creating more bureaucracy to manage the HIV/AIDS treatment programme. The separate ARV depot has insured that ARVs[7] were available at all ARV clinics at any given time, making clinics able to provide the life saving medication. It

[7] A full list of ARVs stocked in the ARV depot is attached as an annex

would clearly be better if PAWC incorporated the ARV depot into the general depot, and made sure that all drugs, not only ARVs were available to all clinics at any given time.

The picture below is from the ARV depot's first days, when they were still waiting for the proper refrigerators, hence the borrowed ones from Coca Cola:

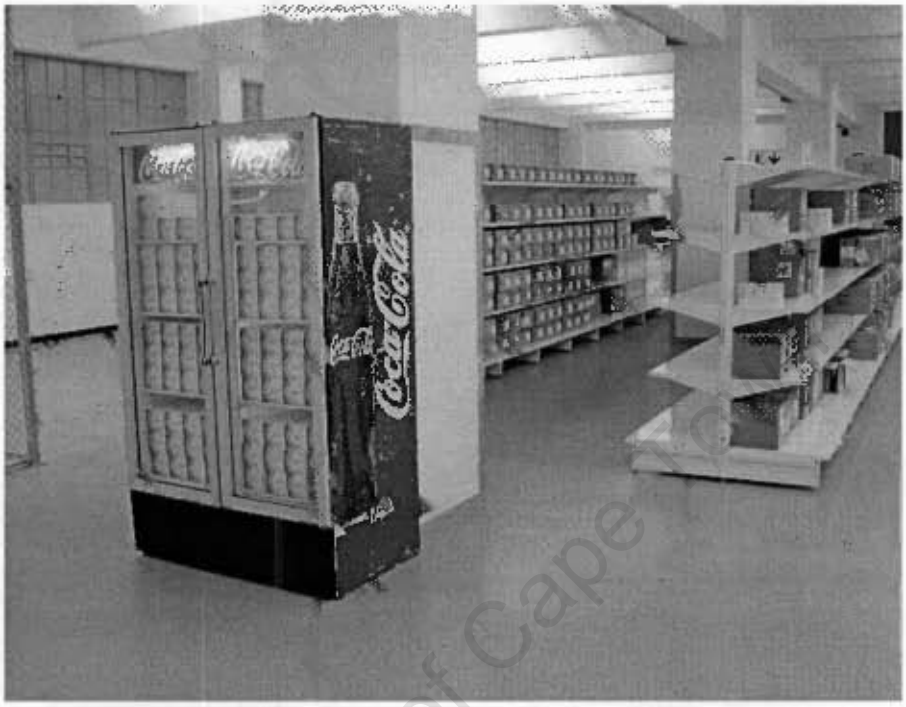


Figure 15 ARV Depot (L. Channing, Health Department of the Provincial Administration of the Western Cape, 2005)

ARV Treatment Sites

In the grant project's first two years, the Global Fund provides funds for ARV Treatment sites within the metropolitan region of Cape Town. The five ARV sites that received Global Fund money were: (CHC refers to community health clinic)

- Gugulethu CHC
- Khayelitsha: Site B CHC
- Khayelitsha: Site C CHC
- Khayelitsha: Michael Mapongwana CHC
- Masiphumelele Clinic

All the five clinics were within the greater Cape Town area and were co-run by an NGO. The clinics were all pilot research sites prior to the Global Fund money. It was a deliberate choice from PAWC to put the money where they knew it would work (Abdullah, 2005, personal comm., 20 July). It would be easier to have a successful programme that could build on something, i.e. upscale as opposed to starting from scratch (Abdullah, 2005, personal comm., 20 July). After the rocky start of the KwaZulu-Natal grant, it was increasingly important for the Global Fund and the Western Cape that this project was a successful grant. By choosing already well-functioning clinics with around 1000 people on ARV treatment, and by planning the upscale in great detail, Western Cape insured themselves against failure, and had perhaps the best foundation for a successful grant.

The success of the ARV component of the grant has been measured by the cumulative number of patients on ARV treatment at each of the ARV Treatment Sites.

Global Fund Grant Objective 1: ARV Treatment Year 1						
Key Indicators			**Intended results/targets in year 1**			
			Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Objective 1	Cumulative number of patients started on ARV treatment at 5 sites	Gugulethu	410	560	710	860
		Khayelitsha Site B	490	580	670	760
		Khayelitsha Site C	395	470	545	620
		Khayelitsha Michael Mapongwana	375	450	525	600
		Masiphumelele	95	170	245	320
		Total	**1765**	**2230**	**2695**	**3160**

Figure 16 GLOBAL FUND GRAND OBJECTIVE 1: (ADAPTED FROM THE GLOBAL FUND MONITORING AND EVALUATION PLAN, WESTERN CAPE DEPARTMENT OF HEALTH, 2004D)

As seen in the above table, each clinic was given specific targets. The number of patients starting on ARV treatment, and the number of patients discontinuing treatment are also presented in progress reports (Frankish, 2005, personal comm., 22 July). The report includes targets of how many new patients should start treatment in relation to achieving the total figures of people on ARV treatment. The focus of this dissertation is on the total target numbers not each segment.

The grant money from the Global Fund only arrived in October 2004. The province initially wanted to start the programme in July 2004 (Frankish, 2005, personal comm., 22 July). An

agreement with the Treasury provided bridging finance, enabling the program to start early on 1 July 2004 (Frankish, 2005, personal comm., 22 July). Once the money from the Global Fund arrived, the programme start date was made retrospective to coincide with the actual programme start date (Frankish, 2005, personal comm., 22 July). Thus the first year of the grant is from 1 July 2004 - 30 June 2005. Thus the first year of the grant SAF-304-G04-H is from 1 July 2004 - 30 June 2005.

The following is a brief account of each clinic:

Gugulethu CHC Site:

The Gugulethu CHC has been providing ARV treatment to infected people since September 2002 (Wood, 2005, personal comm., 9 Sept). The clinic is co-funded by CRUSAID and other organisations (Wood, 2005, personal comm., 9 Sept). It is managed and run by PAWC and the Desmond Tutu Foundation, led by Prof. Robin Wood. The number of patients on treatment by the end of June 2004 had reached 289.

The Global Fund grant provides for the continuation of the ARV treatment for those original 289 patients who started treatment prior to the start of the Global Fund project in Gugulethu. In addition the grant provides supplementary personnel, ARV medicines and laboratory investigations. A new HIV/AIDS clinic building, funded by the Western Cape Department of Health, was completed at Gugulethu CHC in the fist year of the Global Fund grant. Additional funding provision from the Global Fund grant also supported the purchase of furniture and non-medical equipment for the new clinical building. A total of 825 patients were on ARV treatment at Gugulethu in the end of June 2005. Gugulethu fell 35 patients short as the target was to have 860 patients on treatment. The reason for Gugulethu's slow upscale is related to an extra required building being set up (Slingers, 2005, personal comm., 1 Sept). Once the building was up and running Gugulethu started catching up with its targets.

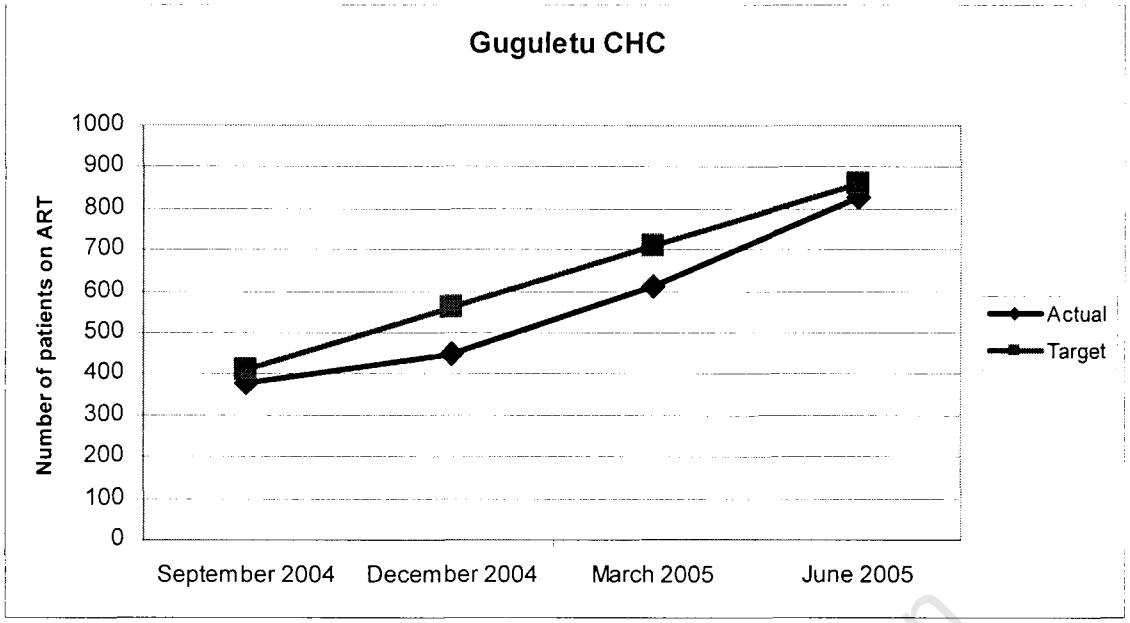


Figure 17 PATIENTS ON ART IN GUGULETHU CHC: SOURCE: CLOETE, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005

Masiphumelele Site – Fish Hoek

The Masiphumelele site is a collaboration of research projects involving the Chris Hani Baragwanath Hospital, the National Health Laboratory Service, the University of Stellenbosch, the University of the Witwatersrand, and the University of Cape Town. It is supported by the Provincial Health Departments of the Western Cape. The staff, monitoring and research costs of the project are funded by the National Institute of Health, USA. The clinic was originally set up in 2004 (Wood, 2005, personal comm., 9 Sept).

The Global Fund grant provided programme furniture and non-medical equipment for a new building. No additional personnel are funded by the Global Fund. The number of patients on treatment by the end of June 2004 was 27, and The Global Fund programme provided continuation of ARV treatment of those 27 patients who had started treatment prior to July 2004. The target was to have a total of 320 patients on ARV treatment after one year with the Global Fund project, and in June 2005 a total of 222 people were on treatment, well below target. The challenge in Masiphumelele has not been related to infrastructure and staffing, it has, according to Dr. Nevilene Slingers, rather been a question of high disapproving stigma in the community. Masiphumelele is a very small community compared to Khayelitsha, and stigma is more prevalent (Slingers, 2005, personal comm., 1 Sept).

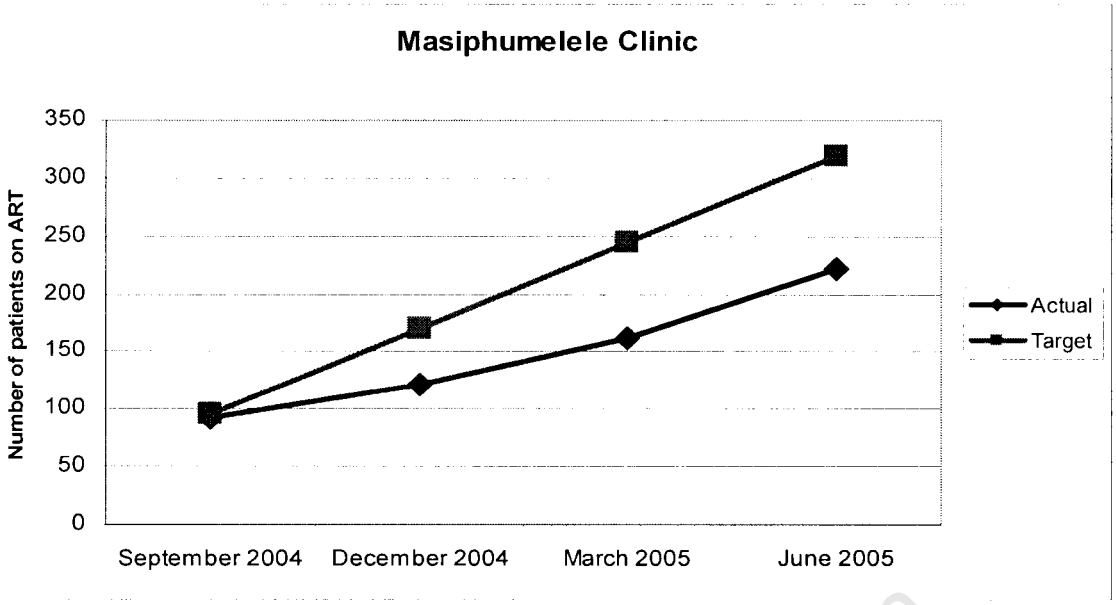


Figure 18 PATIENTS ON ART IN MASIPHUMELELE CLINIC. SOURCE: CLOETE, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005

MSF sites in Khayelitsha:

Médicins Sans Frontières (MSF) runs three of the five clinics that are receiving funding from the Global Fund. The three clinics have been providing ARV treatment since 2001 in Khayelitsha.[8] The Global Fund grant provides additional staff, ARV drugs, laboratory services and non-medical equipment such as furniture in all three clinics. MSF funds 300 patients at the Michael Mapongwana CHC, while the Global Fund funds the rest. A total of 2272 patients were receiving ARV treatment at these three sites in the end of June 2005.

Khayelitsha Site B CHC:

The Khayelitsha Site B CHC has been providing ARV treatment since 2001. The number of patients on treatment by the end of June 2004 was 422. The Global Fund programme provided continuation of ARV treatment of those 422 patients who had started treatment prior to July 2004. The target was to have a total of 760 patients on ARV treatment after one year with the Global Fund project. In June 2005 a total of 880 people were on treatment. In its first year Site B exceeded its target by 120 patients.

[8] The three clinics are the same clinics as those mentioned in the previous chapter on the Western Cape.

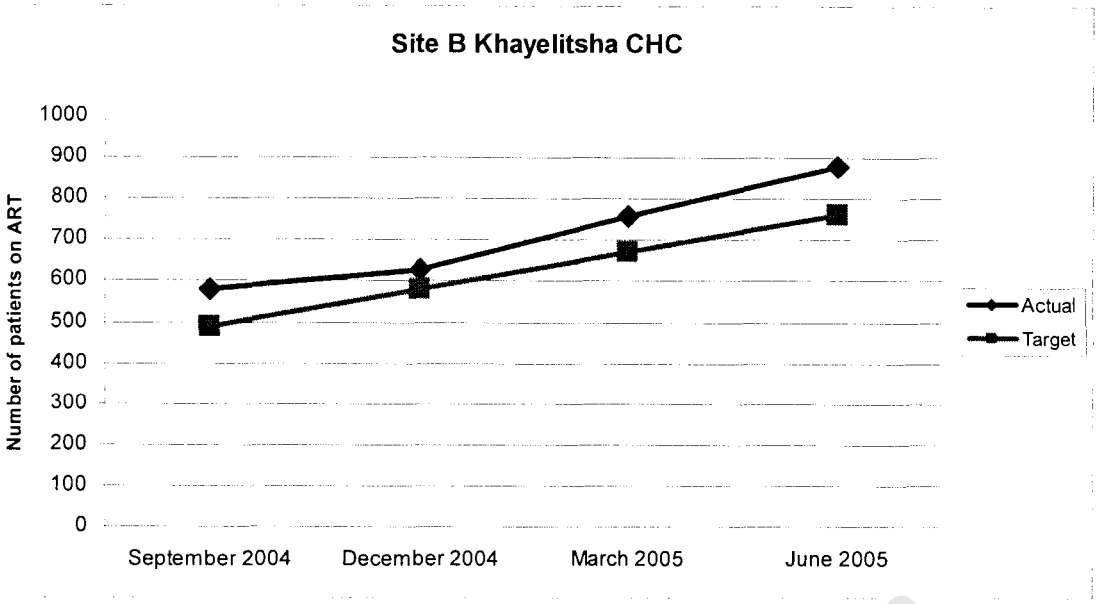


Figure 19 PATIENTS ON ART IN SITE B KHAYELITSHA. SOURCE: CLOETE, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005

Khayelitsha Site C Nolungile CHC

The Khayelitsha Site C CHC has been providing ARV treatment since 2001. The number of patients on treatment by the end of June 2004 was 359. The Global Fund programme provided continuation of ARV treatment of those 359 patients who had started treatment prior to July 2004. The target was to have a total of 620 patients on ARV treatment after one year with the Global Fund project. In June 2005 a total of 612 people were on treatment. In its first year Site C almost hit its target.

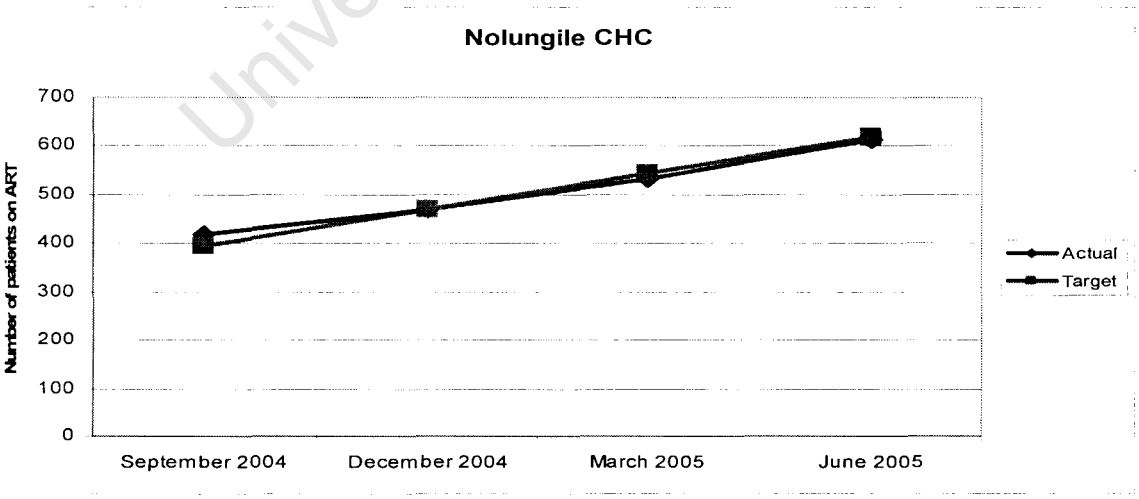


Figure 20 PATIENTS ON ART IN NOLUNGILE CHC. SOURCE: CLOETE, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005

Khayelitsha: Michael Mapongwana CHC Site

The Michael Mapongwana CHC has been providing ARV treatment since 2001. The number of patients on treatment by the end of June 2004 was 340. The Global Fund programme provided continuation of ARV treatment of those 340 patients who had started treatment prior to July 2004. The target was to have a total of 600 patients on ARV treatment after one year with the Global Fund project. In June 2005 a total of 780 people were on treatment. In its first year Michael Mapongwana exceeded its target by 180 patients.

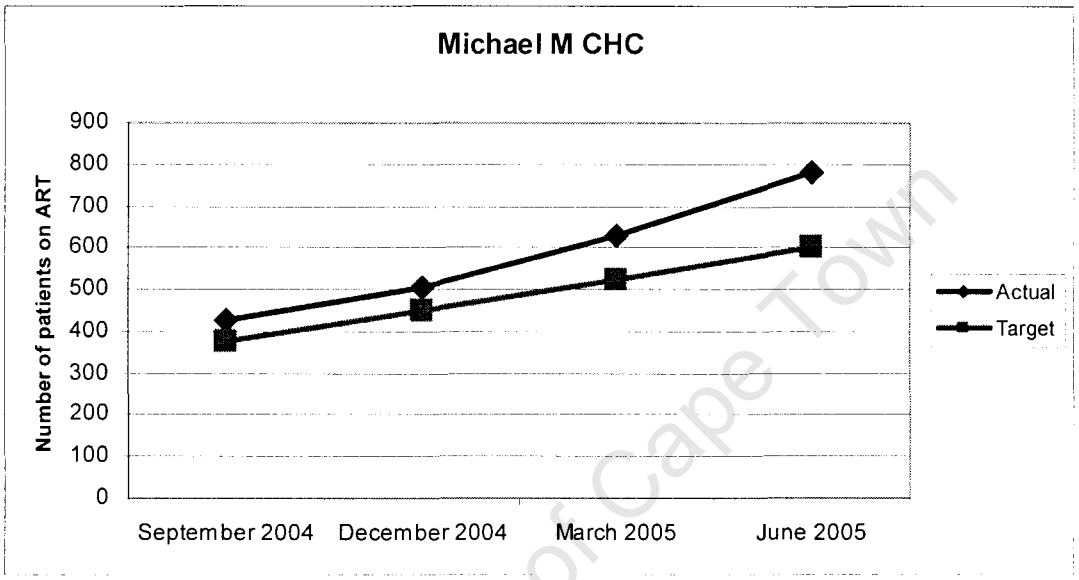


Figure 21 PATIENTS ON ART IN MICHAEL MAPONGWANA CHC. SOURCE: CLOETE, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005

The 5 Global Fund ARV sites combined

As a whole the Global Fund grant has managed to meet or exceeded its ART targets. The number of new patients who started on ARV treatment with Global Fund money has constantly performed well. Discontinuing rates, as people stop taking the medication, move or die will naturally affect the cumulative number of patients on ARV. The grant has managed to hit its targets, despite some clinics performing under target. For the first year of the Global Fund grant the target was to have 3 160 patients on ARVs at the 5 funded sites. The actual number was 3 319 by the end of June 2005.

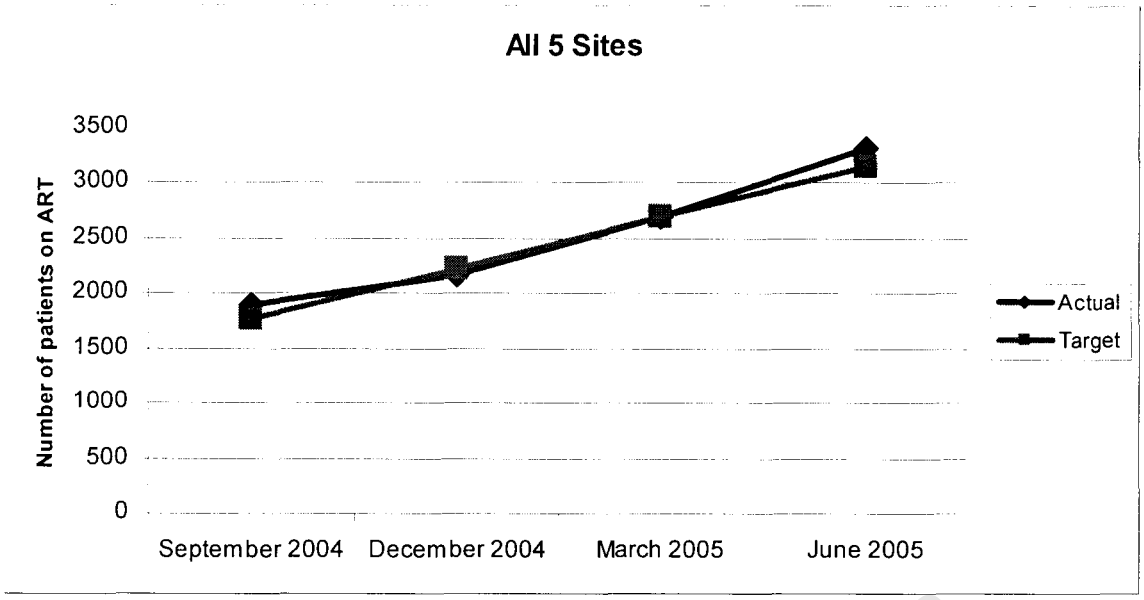


Figure 22 PATIENTS ON ART IN ALL 5 SITES (CLOETE, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005)

The numbers shown above are total accumulative numbers, stating the total number of patients on ARV treatment at the given times. In the grant agreement those figures are based on the fact that 465 new patients start treatment each quarter. The numbers below tells how successful the grant has been in putting new patients on treatment in the first year of the grant. Overall the target was to start 1860 patients on treatment within a year. The actual result was 2216, clearly exceeding the target. It is interesting to note on the chart that there was a decline in new patients during the summer/Christmas period, which is most likely due to people leaving for holiday and low capacity uptake in the holiday season.

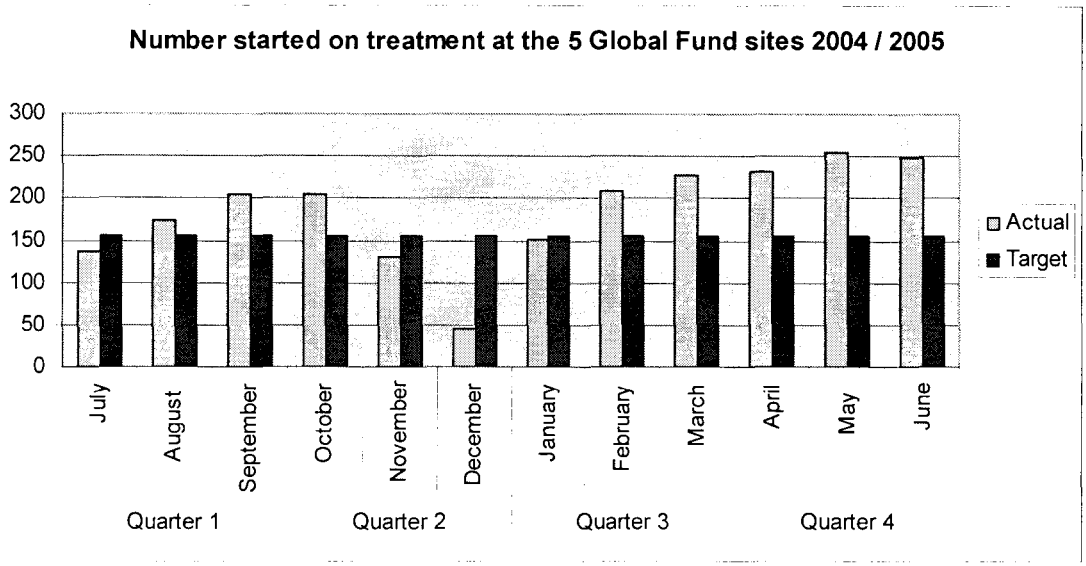


Figure 23 NUMBER STARTED ON TREATMENT AT 5 GLOBAL FUND SITES: (FRANKISH, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005)

The total number of people on treatment at the five sites after one year will depend on how many patients discontinued treatment. During this period 334 patients stopped the ARV treatment at the sites,and these numbers were not built into the targets of the Global Fund grant, however they affect the overall performance as measured in total numbers on treatment. The chart below gives an account of how many patients discontinued treatment. Suspected reasons for discontinuing could be death, dislike of the ARVs (i.e. high toxicity of the drugs), or mobility (patients moving back to rural areas like Eastern Cape). Such reasons are not included in the data presented.

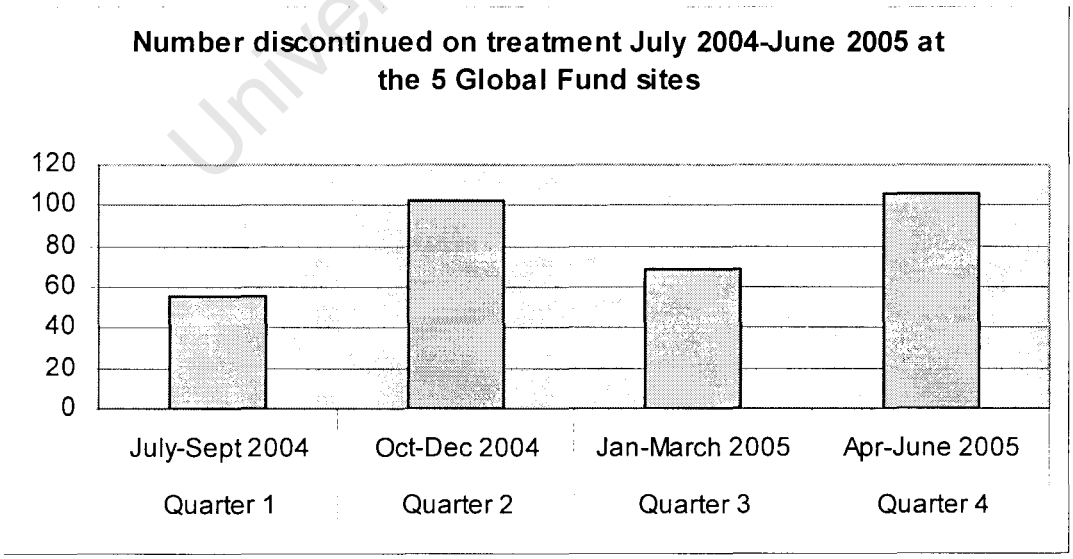


Figure 24 NUMBER DISCONTINUED ON TREATMENT JULY 2004 – JUNE 2005 (FRANKISH, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005)

Despite the discontinuing rates of people on treatment the grant still exceeds its targets, for the first year, both when it comes to new patients on ARV treatment, as well as total number of people on treatment. Based on this the overall ARV component of the grant is successful.

The general rollout in Western Cape

The ARV treatment roll-out in the Western Cape is considered to have so far been a highly effective and successful programme (Abdullah, 2005; Coetzee *et al*, 2004a; Kasper *et al*, 2003; Orrell *et al*, 2003, WHO, 2003) as defined by its capacity to quickly and effectively treat a substantial number of people living with HIV/AIDS while yielding measurable reductions in AIDS-related morbidity and mortality (WHO, 2003).The Western Cape province has managed to put people on ARVs faster than any other province. The well running pilot projects in Western Cape gave the province something to build on.

Following the South African National Cabinet's decision of 19 November 2003 to implement and fund a national HAART intervention in all provinces, and along with the promised grant from the Global Fund, the antiretroviral roll-out began gradually in 2004 (Cloete, 2005, personal comm., 30 Aug). The Western Cape as per December 2006 reaching an estimated 65% of those in need of ARV treatment in the province (F. Abdullah sited in Herman, 2006). This figure coincides with the ASSA AIDS model, which PAWC has used when planning the need of ARV treatment (Abdullah, 2005, personal comm., 23 Sept). Nationally in South Africa, it is estimated that only 10% of those in need of treatment have access to ARV treatment (F. Abdullah sited in Herman, 2006). This supports the view reflecting the success of the Western Cape. Other urban areas like Johannesburg and Pretoria have had a slower start, but have since caught up in total numbers (Cloete, 2005, personal comm., 30 Aug). However, as the prevalence rate is much higher in Gauteng, they will have more people in need of ARV treatment than Western Cape has.

The five Global Fund sites are a part of a planned total of 44 ARV sites by March 2006. In August 2005 there were 39 ARV sites operational, and as of end of July 2005 there were 10 451 people on treatment (Cloete, 2005, personal comm., 30 Aug). The Western Cape has managed to upscale quite successfully, and are beating their own targets. The goal was to have 10 000 people on treatment in December 2005, but they reached this target in July 2005

and in August 2005 the programme enrolled an average of 800 new patients onto treatment monthly (Cloete, 2005, personal comm., 30 Aug).

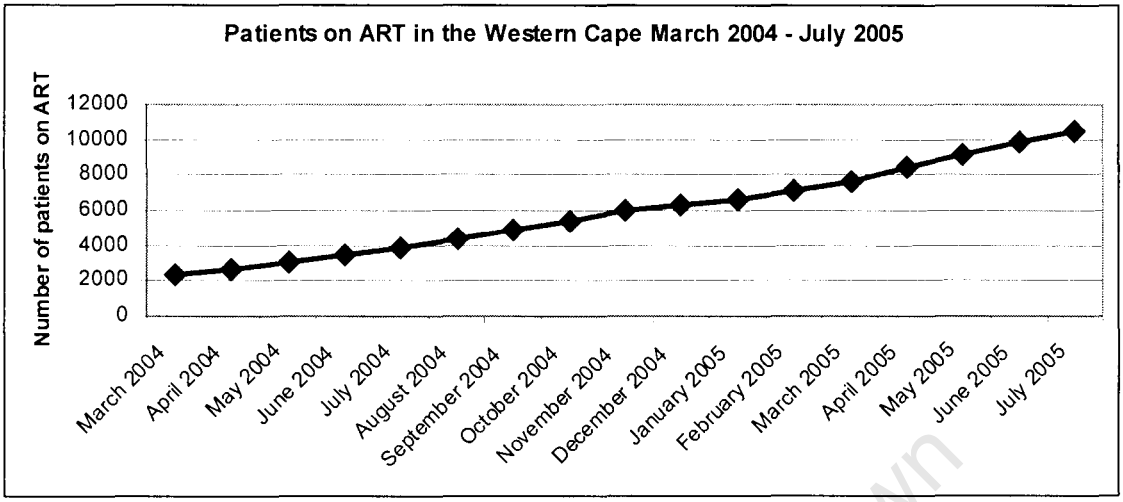


Figure 25 PATIENTS ON ART IN THE WESTERN CAPE MARCH 2004 – JULY 2005 (CLOETE, HEALTH DEPARTMENT OF THE PROVINCIAL ADMINISTRATION OF THE WESTERN CAPE, 2005

Dr. Gary Maartens has categorised the ARV rollout in Western Cape as like a 'military operation' (Maartens, 2005, personal comm., 4 Aug). PAWC has, accordingly to Dr. Keith Cloete, the HIV/AIDS director in PAWC, followed a very detailed and well-planned structure:

"Firstly... a site selection. Then a staffing estimate per site: so many doctors, so many nurses... Then we did a projected patient enrolment at each site, so we build up... so many people will be there in March, so many in April, so many in May and June, and we did it month by month. We then work out how much will it cost drug-wise... how much will it cost for the people and lab-wise for all the investigation and how much will it cost month per month to pay for all the staff for every site that we had, we put all of that into one big business plan and we got about... we had eventually 25 – 30 different excel spread sheets per site to put this whole thing into perspective to kick out one budget schedule. It was actually not just a budget schedule, it was actually just all a month by month plan of enrolment, staff, we knew exactly which month which nurses are going to start... exactly how many patients per site, exactly how much we were going to pay for the lab. ***So it eventually became a detailed month per month plan, which you can equate to a kind of military operation because it got to that level of detail and we roughly stuck to all those targets****..." (Cloete, 2005, personal comm., 30 Aug)*

PAWC had a good working knowledge of operational issues having experience in working with antiretrovirals, both in the MTCT programme and the pilot ARV sites. Thus the Western Cape developed a strategy for the antiretroviral rollout. On the basis of the experiences from the pilot projects Western Cape developed a strategy for the antiretroviral rollout (Abdullah,

2005, personal comm., 20 July; Cloete, 2005, personal comm., 30 Aug). The decision on where to place the ARV sites was based on a combination of geographical access and high HIV prevalence areas (Cloete, 2005, personal comm., 30 Aug). The PAWC annually provides detailed information on the antenatal survey, showing clearly which areas have high prevalence compared to others with low prevalence (Cloete, 2005, personal comm., 30 Aug). An alternative method of providing ART would be to open ARV sites in the high prevalence areas, such as urban areas like Khayelitsha and Gugulethu, and to concentrate on a model based on the antenatal survey. This has not according to Dr Cloete taken place:

'It doesn't matter where you are within the province, you going to have geographic access to a site... the question is not about where the antenatal prevalence site is, its about saying how do you get geographic access across the province and ... to get a balance right between decentralisation and centralisation so that you provide reasonable access from wherever you are in the province. That was actually the determining factor of where the sites were' (Cloete, 2005, personal comm., 30 Aug)

A full list of the sites is attached as an annexure.

CHAPTER 6: Success factors

The Western Cape Global Fund grant has, as seen in the previous chapter, been highly successful in meeting the targets set. The overall rollout of ARVs in the Western Cape has also been described as a success by all interviewed. The same success factors could be attributed to both the Global Fund grant as well as the general rollout of antiretrovirals. This chapter will look at the success of the ARV component of the Global Fund. It will try to summarize the key factors that have contributed to the success.

Low prevalence / Urban setting

The Western Cape had an advantage that enabled them to progress faster than other provinces when it comes to ARV treatment. Many of the interviewees have highlighted the following factors as being major contributors to the successful ARV treatment rollout, both in the five clinics supported by the Global Fund, and in the other ARV clinics in the Western Cape.

The first factor was that the province had a good health structure with tertiary hospitals, mobile clinics and district and community clinics. In addition the Western Cape already had a well functioning health system, with good access to health care.

Secondly, the province is predominantly urban, with the majority of the population living in and around Cape Town. This makes it easier to concentrate on a fewer number of clinics.

Thirdly, Western Cape has the lowest HIV prevalence rate in South Africa, thus the infection rates were lower, and thus more manageable.

Fourthly, Western Cape is fortunate in being able to attract committed health professionals as Cape Town is known to be a beautiful city where people would like to live.

Thus the aforementioned factors have allowed the Western Cape Province to make ARV treatment more manageable than in other less fortunate provinces.

Timing

Timing has played a crucial factor in the success, as the Western Cape was lucky to get a partnership with MSF in Khayelitsha at a time when national policy was opposed to the use of ARVs, both in pregnant women, children and adults. If MSF had not arrived in Cape Town, it

would have taken Western Cape a much longer time to develop the expertise that MSF acquired in Khayelitsha, and hence the Global Fund programme and the general rollout wouldn't have these advantages, and thus the programme might not have been successful.

Timing also played a vital role in the arrival of the Global Fund grant. The grant coincided with the national rollout, which allowed the Western Cape to use the Global Fund money to expand the rollout and go for a spread out model, reaching more areas than they would have reached without the grant money. The provincial administration could plan for the rollout and make the Global Fund five sites a part of the bigger plan. There was no need to produce one detailed plan for the Global Fund ARV sites and separate one for the national money; it could all be planned together. This saved the management time and recourses and it ensured a holistic plan where the Global Fund sites were five selected sites out of the planned 44 sites.

Had the Global Fund grant been approved in round two, and not in round three, then the grant would most likely have arrived at a time when the South African national government was opposed to free ARVs through the public health system, which would probably have made it more difficult to achieve success with the program and would most likely of raised more controversy around the topic.

Experience through partnerships

A key to the success of both the Global Fund supported ARV programme and the general rollout of ARVs in the Western Cape has been successful partnerships between PAWC and independent organisations. Two partnerships have been extremely important for the success of the Global Fund grant:

- Médicins Sans Frontières (Khayelitsha)
- Desmond Tutu HIV Centre (Gugulethu)

These two partnerships were particularly vital in the early days of the rollout when national policies were against public ARV treatment. These organisations produced vital research on how to provide ART in resources poor environments, proving that adherence to the drugs

was as good as in developing countries.[9]

The partnerships, especially the MSF partnership on prevention of mother-to-child transmission of HIV, which started as early as in 1999, gave the Western Cape Department of Health an opportunity to gain vital experience in managing ARVs in a resource poor communities while the national debate was raging. This has been categorised as a smart move by the provincial administration.

"Fareed (Abdullah) was clever enough putting this totally as private research, but in fact in governmental site. So in fact, in a way he protected himself from the rage of national. So he could always claim "oh, no it is not us" But at the same time he could benefit from the experience" (Goemaere, 2005, personal comm., 5 Aug)

Although antiretrovirals were available in the private health sector at the time, PAWC had limited experience with implementing and managing ARV treatment, and it would be a fair comment to say that they would not have been able to gain the same level of experience without the MSF partnership in Khayelitsha.

"And MSF has helped. Great help of course... I mean the Khayelitsha pilot and showing that it worked and dealing with all the problems... and MSF involvement in Khayelitsha... putting out papers and things that showed that they were able to keep the compliance and all that so it wasn't as dangerous for people to worry about, has also strengthened our hand at an early stage". (Toms, 2005, personal comm., 23 Aug)

"I think they would have been able to have significant pilot sites operational, but not to the scale. Not as early as 2000/2001, not at the scale of Khayelitsha, and not in Khayelitsha, because I mean the MSF involvement was the key to starting a lot earlier before any other organisations got going a bit later when more funding became available etc. I think Khayelitsha as a surface context was a very challenging surface context... and not many other NGOs would have chosen to start there... and I think having a partner with a strong political and advocacy vision was important at the time, given the political context". (Boulle, 2005, personal comm., 10 Aug)

When the pilot sites initiated ARV treatment both in Khayelitsha and in Gugulethu, PAWC was able to gain uniquely different experiences, from two different communities with high HIV prevalences. Khayelitsha is a more mobile community, with great influx of patients from Eastern Cape, while Gugulethu is a much more stable community (Slingers, 2005, personal

[9] See Coetzee et al (2005), Coetzee et al (2004), Kasper et al (2003), Orrell et al (2001), Orrell et al (2003), World Health Organization (2003)

comm., 1 Sept). The two projects also operated with different counselling models and thus these experiences gave PAWC great insight in ARV discontinuing rates. In July 2005 PAWC had not decided on which model provided the pest result (Frankish, 2005, personal comm., 22 July).

From 2000/2001 the Western Cape developed other partnerships on ARV treatment. The partnership with the organisation 'Kidzpositive' at the Groote Schuur Hospital in Cape Town provided vital insight into paediatric ARV treatment (Abdullah, 2005). In addition PAWC supported other research projects, which also provided useful information on ARVs. PAWC has since 2003 had a strong partnership with 'Absolute Return for Kids' (ARK), a non-governmental organisation. ARK helped with the upscale of new ARV sites, by bringing in a team of doctors, nurses and/or pharmacists to rapidly improve capacity at the site (Cloete, 2005, personal comm., 30 Aug). This happened at many of the ARV sites, however not at the five sites funded by the Global Fund.

The pilot projects in 2000 represented the starting point of providing antiretroviral treatment in Western Cape. The later general rollout, in 2004 started with the pilot sites then gradually expanding to other sites[10]. The 4 Global Fund sites, which were previous pilot sites, expanded and upscaled the ARV treatment. The fifth site, the Masiphumelele site in Fish Hoek, Cape Town, was set up in late 2004 with the knowledge gained in from the pilot project in Gugulethu (Wood, 2005, personal comm., 9 Sept).

For the Western Cape, partnerships have been an essential component in the fight against AIDS. By creating partnerships the province was able to expand their projects and gain more knowledge than they would have done without the partnerships. The early experience in providing antiretroviral treatment in poor communities in Khayelitsha and Gugulethu gave the Western Cape an advantage over other provinces. This was, according to Dr. Fareed Abdullah11, the main reasons for the quick upscale and early success (Abdullah, 2005, personal comm., 19 July).

Involvement of civil society

[10] A full list of ARV sites pr. July 2005 is attached as an annex.
[11] Dr. Abdullah is the Western Cape Deputy Director General: District Health Services and Programmes

The provincial administration in the Western Cape had a strong partnership with civil society (Cloete, 2005, personal comm., 30 Aug). The province has important partnerships with non-governmental and international organisations, like MSF and the Desmond Tutu Foundation. In addition the Western Cape had a strong relationship with the activist organisation the Treatment Action Campaign (TAC), with ARV counselling in the Western Cape being outsourced to NGOs like TAC. The Treatment Action Campaign promoted patient advocacy, which insured a strong community involvement mainly through their involvement at most of the urban ARV sites. This is evident in Khayelitsha were HIV services were developed alongside strong civil society pressure and community-based education programmes.

"I mean the main success factor is the involvement of TAC, we came with a technique – a technical proposal, its possible to treat HIV ... So TAC has been very useful here, in by the way; TAC and MSF developed together here in Khayelitsha. When we arrived they were at an office in town, they were a few, a few people that formed the community-based community rooted TAC – they come from all sorts of places, some they decide to disclose and that's something useful for the treatment of the people so that is an enormous factor" (Goemaere, 2005, personal comm., 5 Aug)

The Treatment Action Campaign acted on a provincial and national level, mobilising the community, making HIV/AIDS and access to ARVs as a political issue.[12] TAC has educated many people in the community about HIV/AIDS, prevention and ARV therapy ("treatment literacy"). In Khayelitsha, TAC's Project Ulwazi ("knowledge") used HIV positive people to educate the community, with the goal of promoting disclosure and reducing stigma (MSF *et al*, 2003).

"The Treatment Action Campaign brings with it a completely different dimension in terms of their partnership. It was more a partnership of encouraging people on the ground to engage in the treatment program and doing a lot of mobilisation in communities where the treatment is needed, and doing a lot of treatment literacy and a lot of things that kind of combat stigma with an exceptional groundwork in terms of making the Western Cape a fertile ground for a good roll out program. So that it's dealt with a lot of programs that we would never be able to cope with or begin to deal with if we had to do it in absence of that partnership." (Cloete, 2005, personal comm., 30 Aug)

Although difficult to prove, TAC's involvement in Khayelitsha, in combination with MSF and

[12] TAC has been on the forefront demanding access to treatment. They have, among other things, taken the health minister to court for not allowing HIV positive women to be treated with ARVs so that the babies would have a reduced risk of transmission. For more information on TAC see www.tac.org

the provincial administration in the Western Cape might have created more openness and knowledge around HIV and AIDS, and possibly reduced stigma. More people in Khayelitsha were coming forward for HIV tests and wishing to know their status than in any other community, with 60% of women aged 20-24 years had taken an HIV test (Eric Goemaere quoted in Rosenberg, 2005). In South Africa, generally, it is believed that the vast majority of the people do not know their HIV status. No other community in South Africa can show such high results as Khayelitsha (Eric Goemaere quoted in. Rosenberg, 2005). This indicates that there is might be more openness around HIV/AIDS in Khayelitsha than in many other areas.

'Ok. TAC... you know that's a good one. I think in Khayelitsha they've been particularly good, hey... and I mean just overall they're good. But in Khayelitsha they've been particularly good. And how I think they've helped amazed me. You see I don't think we've had to use... where in a sense nationally TAC has had to be in a sense on the attack to try and force government to do things. Here in the Western Cape, TAC and Fareed are particularly very close you know... and they've been able to affirm what we've been doing rather than attack it, and I think that's a better relationship and so they've been able to put their energies into helping people understand the treatment, understand what the drugs are, understand sort of the potential fall-outs and things like that why they shouldn't... So I mean a young client in Khayelitsha on antiretrovirals probably knows more about the drugs and the side effects and all that than I do, just about... I mean they're amazingly informed.' (Toms, 2005, personal comm., 23 Aug)

In addition to TAC, many other organisations have been active in the fight against HIV/AIDS. Academic institutions and researchers have also been involved in discussions on ARV treatment (Maartens, 2005, personal comm., 4 Aug). The combination of all these initiatives has helped to create a united environment in Western Cape promoting openness around HIV/AIDS.

Synergy

The united environment around HIV/AIDS in Western Cape created by the involvement of civil society created openness and unity. The pilot projects and the partnerships made people think that there was a will to do something in the Western Cape. The provincial HIV/AIDS administration in the Western Cape was seen as credible; they were doing all they could, in light of the national policies, to initiate ARV treatment. All actors in the fight against AIDS were in agreement. There were no disparities and controversies like at the national level. In the Western Cape all parties wanted to fight AIDS. The government, local authorities, NGOs, international donors and clinicians, All were working together to do their best under the circumstances. By working together for treatment and against the national government made

Western Cape stand out at the forefront in the fight against AIDS. The province was seen as innovative, responsive and all-inclusive, attributes which helped it to attracted staff and better resources to the Western Cape. Greater trust from civil society and the public led to less criticism.

There was also a strong connection and between the three leading institutions/organisations via the three leading men; Fareed Abdullah (PAWC), Zackie Achmat (TAC) and Eric Goemaere (MSF), in the fight against AIDS. This naturally eased tension, and helped create synergy.

"Here in the Western Cape, ***TAC and Fareed (Abdullah) are particularly very close****..."*
(Toms, 2005, personal comm., 23 Aug)

Dr Eric Goemaere on his relations with Dr Fareed Abdullah:

*'****Excellent*** *- from the beginning; very fruitful. I mean I've been doing this work for MSF for more than 30 years and* ***it's definitely the best relation I have ever had****. With national it is probably the worst I have had.' (Goemeare, 2005, personal comm., 5 Aug)*

'I think the word for me would be ***"synergy",*** *particularly with Khayelitsha. TAC, province, city... um, youth centres, NGO's involved, MSF, you know... you've got this synergy going, they really and* ***they work together, they think together, they understand each other, they're a team****' (Toms, 2005, personal comm., 23 Aug)*

Leadership/Management

The decision to involve civil society and establish partnerships was taken by the HIV/AIDS management team, led by Deputy Director Dr Fareed Abdullah. In this research the management style of the HIV/AIDS team in Western Cape has come out as an important factor in the success of the Global Fund grant. Almost all interviewed, in the research process, acknowledged the importance of Dr Fareed Abdullah's leadership and his team's well functioning management style. Several visualised how well the Western Cape functioned in comparison to the neighbouring province of the Eastern Cape, where things run much less smoothly. One interviewee went as far as saying that working in the Eastern Cape was impossible without a drastic change in management. However since the focus of this dissertation is not on the Eastern Cape, this section will explore what made the ARV objective of the Global Fund grant so successful in the Western Cape.

For any programme to be successful you need good management and well functioning systems in place. This is particularly important in the context of the Global Fund. The Global Fund requires progress reports and the Local Fund Agent assesses the grant performance, making monitoring and evaluation a crucial part of grant management. If a grant is not performing well, and not reaching its targets, or if it is not accountable, then the grant faces the risk of termination. This has recently been seen with the Global Fund grant to loveLife in South Africa. LoveLife applied for 'phase two' funding, however the application was declined. This resulted in loveLife loosing one third of its funding, which naturally has adverse implications on their project. The grant given to Western Cape will also face termination if it does not continue performing well, thus good management to meet targets will be vital.

In the Western Cape, Dr. Fareed Abdullah was in charge of the HIV/AIDS team, which is also the unit that is responsible for the Global Fund grant (Global Fund, 2006). The implementation and management of the Global Fund grant had been carried out within existing programmes in the provincial administration in Western Cape (Frankish, 2005, personal comm., 22 July), and parallel systems and structures, apart from the special ARV depot, have not been developed (Abdullah, 2005, personal comm., 19 July). Even though the existing management personnel, structures and systems have managed and implement the Global Fund grant, only a handful additional personnel were appointed in the first year of the grant to coordinate the Global Fund aspects of the already existing programmes (Frankish, 2005, personal comm., 22 July).

One dedicated manager, Dr. John Frankish acts as the Global Fund Manager in Western Cape and the HIV/AIDS management team also deals with the daily managing of the Global Fund grant (Frankish, 2005, personal comm., 22 July). A few other key personnel have been hired to make sure the team produces regular operational, monitoring and financial reports as required by the Global Fund, and makes sure the grant performs well (Frankish, 2005, personal comm., 22 July) They can be summed up as:

- One Provincial Global Fund Programme Manager
- One Provincial Global Fund Financial Administrator
- Four Regional Global Fund Financial Administrators
- One Regional Global Fund Peer Education Administrator

All involved in the administrating and managing the Global Fund grant met monthly to discuss

the progress of the grant (Abdullah, 2005, personal comm., 19 July). These meetings created peer pressure with regards to performance, making the responsibilities more focused on meeting targets (Naidoo, 2005, personal comm., 1 Aug). Thus this management and infrastructural supporting frameworks can be attributable to the successful management and meeting of targets for the Grants.

"... It's almost the perfect example. I've never seen such a good example of funding that instead of making people dependent, ***stimulate their ambition****" (Goemaere, 2005, personal comm., 5 Aug)*

The members of the antiretroviral management team who were interviewed for this dissertation all highlighted the good team spirit and that the team was very strong;

"I think we've got a ***very good team spirit*** *... dealing with the Global Fund was actually quite a good team-building exercise" (Cloete, 2005, personal comm., 30 Aug)*

Dr Fareed Abdullah has been responsible for the Western Cape's AIDS programme since 1995 (Herman, 2006). In 1999 he had the courage and dedication to start the first HIV prevention programme of mother to child transmission in South Africa (Goemaere, 2005, personal comm., 5 Aug). Abdullah also had the foresight to sign an agreement with MSF to do pilot research on ARVs (Goemaere, 2005, personal comm., 5 Aug).

'It was a political risk...' 'The ***management style was fantastic****' (Maartens, 2005, personal comm., 4 Aug)*

'There were these huge tensions with the national minister and she was saying that AZT was poison...' (Toms, 2005, personal comm., 23 Aug)

It takes a strong leadership to go against national policies; it takes a visionary to unite the province. It takes charisma and motivation to attract good a good management team. These are all qualities about Dr Fareed Abdullah that have come up in interviews. Many have attributed the success of AIDS treatment in the Western Cape to a large extent to Dr Abdullah's drive and commitment.

'I think a huge amount of that must go to Fareed's (Abdullah) ***drive and commitment****... That I fully take my hat off for what he's done in terms of that and be able to put together that Global Funding document and make it really work... That's brilliant'. (Toms, 2005, personal comm., 23 Aug)*

*'Fareed (Abdullah) is also a **very strong leader and a good visionary**. He always challenges you, but supports you to the goal... like he he'll say "We are going to do this..." and we'll all look at each other and think oh how are we going to do this? I don't know if it is his charisma or what it is, but somehow he inspires us to get there and he supports us through the process as well which has been great. I think **he is also one of our KEY success factors**.' (Channing, 2005, personal comm., 25 Aug)*

Dr Abdullah also had the vision to apply for funding from the Global Fund despite the controversies in KwaZulu-Natal. When MSF's Dr Eric Goemaere was asked "could it have been done without him?" he replied:

*"I'm not sure. It's a good question, and relevant question. I'm not sure... his skills, his style; **he is very good in creating a team**. He managed to create a management team – Have you see a management team like that at national level? It is a big job and he has **charisma, vision**, he sees far, and that makes a big difference I think." (Goemaere, 2005, personal comm., 5 Aug)*

All through the research the role that Dr Fareed Abdullah's played in the management of the grants was mentioned repeatedly, and he has been described as the driving force for the ARV success in Western Cape. He was said to be a good visionary leader, who motivated his staff. Many highlighted his ability to put together a strong ARV management team.

*'I think that Fareed is quite lucky and fussy in terms of the fact that he tends to chose hand picked people that he involves in his team... He is clearly **a very committed person**... He is very honest and respects whatever you say... He chooses people who are highly motivated, who can get the job done, and who have done well and shown that they can do well in difficult circumstances. Those are the people that he has pulled into the team'. (Slingers, 2005, personal comm., 1 Sept)*

*'I think one of the things that Fareed did, in his wisdom did **bring a pharmacist into programme, which never happened before**. So very often I would sit in meetings and they will be planning things, planning changes and obviously a pharmacist could see things from different perspectives... A clinician would say 'we need this treatment' a pharmacist might say 'look we have this stock, it's worth this amount of money and we need to get rid of it before we can...' so we just see things differently. So I think it was very good that Fareed brought a pharmacist into programs in general and then specifically into the ARV. I form part of a core team so we have somebody looking after clinical, somebody looking after the site... I look after medicines and pharmacy related issues and I think that helped a lot as well.' (Channing, 2005, personal comm., 25 Aug)*

*'It is a **very strong team**' (Slingers, 2005, personal comm., 1 Sept)*

Dr Fareed Abdullah was especially given credit for hiring Dr John Frankish (Boulle, 2005, personal comm., 10 Aug).

*'We are very **lucky to have John** (Frankish)' (Slingers, 2005, personal comm., 1 Sept)*

*'John Frankish is no 'nobody' you know, these guys manage huge budgets, they know about management, and of course there's the whole capacity. I hear in another country is too complicated the Global Fund, and **here its works perfectly**. Again, on both sides there were good political reason to make sure it worked and rapidly. But it was sort of a **dream story** because of the relations with the Global Fund, we were helping each other in the best way to create out of it the best outcome we could have, and the Global Fund has stimulated their energy, their enthusiasm and their ambition." (Goemaere, 2005, personal comm., 5 Aug)*

It was a calculated management decision to select the five chosen Global Fund ARV sites (Abdullah, 2005, personal comm., 20 July). Starting up new ones would have demanded more work and would have been riskier (Naidoo, 2005, personal comm., 1 Aug). It was also calculated to keep the number of ARV sites in Western Cape to a low number around 40 (Cloete, 2005, personal comm., 30 Aug). As by limiting the number of clinics it was easier to manage the ARV supply, and to ensure that they were adequately staffed (Cloete, 2005, personal comm., 30 Aug). By following this strategy the Western Cape made sure that they reached their Global Fund targets and reached as many people in the shortest time with ARVs (Cloete, 2005, personal comm., 30 Aug).

*"As I say it's almost the **perfect example**. I've never seen such a good example of funding that instead of making people dependent stimulate their ambition, I mean, they could have... they could have sit on the global fund money and stick to that but they say ok, we can get that bit and save a bit of money and do it elsewhere. So I know that they could have asked national well, why it works so much. No, no, they really pushed the roll- out - the provincial roll out as far as they could, save in ⅓ from the global fund to invest else where." (Goemaere, 2005, personal comm., 5 Aug)*

Limiting the number of province run ARV sites was a bold strategy, which has received a lot of criticism for being a short-term solution (Goemaere, 2005, personal comm., 5 Aug; Toms, 2005, personal comm., 23 Aug). The ARV treatment is managed by the province, it has its own medical depot, and it is provided in selected clinics only. The programme has not been integrated into the primary health care setting, as have the treatments for opportunistic diseases such as Tuberculosis have been. This could be problematic in the long run, but was described as a short-term necessity for the Western Cape (Cloete, 2005, personal comm., 30 Aug). This strategy ensured that the PAWC reached as many HIV positive people in need of ARV

treatment as fast as possible (Abdullah, 2005, personal comm., 23 Sept). And when people where dying of AIDS, it was important to save as many as possible as quickly as possible. However, the understanding is that after some years the ARV programme will be incorporated into the primary health care system, ensuring even broader access (Abdullah, 2005, personal comm., 23 Sept).

CHAPTER 7: Challenges

Key success factors such as partnership, experience, timing, management and synergy have all contributed to the success of the Global Fund grant in Western Cape. Even though the Western Cape and the Global Fund grant are seen as successful by many of the people interviewed for this dissertation, several challenges still remain.

Firstly, the numbers of people who need ARVs is increasing, and will keep increasing for the foreseeable future, and if nothing changes this poses challenges in infrastructure and staffing. PAWC has gone for a wide spread ARV rollout model with 44 sites. This model is not designed to incorporate all the HIV positive people who are or will be in need of ARVs for the next 10 to 20 years. Clinics which operated on maximum capacity in 2005 will naturally need to expand capacity to be able to operate in 2006 and 2007. If this means that there will be needs such as an extra building and additional staff, these are challenges that have to be met by PAWC. Often building an extra facility takes a number of years with a slow moving bureaucracy like the Western Cape (Cloete, 2005, personal comm., 30 Aug). This was evident when the Gugulethu ARV site needed a new building to be able to scale up the provision of ARVs in 2004 (Slingers, 2005, personal comm., 1 Sept). This building was completed in 2005, resulting in the uptake of patients rising dramatically. This new building was according to Slingers, 2005 (personal comm., 1 Sept) the reason for the Gugulethu site meeting its Global Fund targets.

The MSF in Khayelitsha did not possess that kind of patience and set up an extra building themselves (Slingers, 2005, personal comm., 1 Sept). This is well and good for the patients who need ARVs in Khayelitsha, but it highlights a potential huge challenge for PAWC's ARV management team. In the longer term, what will happen when the 44 sites reach absolute maximum capacity? The PAWC has chosen a rather vertical approach to ARV delivery. The drugs are supplied by a special ARV depot, and given at special ARV clinics. This vertical approach will need to be generated into the primary health care to insure best possible access, both in terms of people needing treatment and geographical access. Studies have clearly shown that vertical policies often are favoured for a quick and easy outreach, never the less; fail to achieve the same level of success in the long run. The best possible solution for ARV delivery in Western Cape is through a horizontal approach; through the nurse driven primary health care

service. This will be a huge challenge for PAWC to integrate HIV/AIDS with other diseases like TB at a primary health care facility. ARV drugs should also be integrated in the general depot, and that can pose big challenges for the province. Quick fix solutions might be essential in reaching big numbers but to achieve universal access to ARV treatment, one needs to focus on long term issues. People are still getting infected by HIV, and the number of patients needing treatment will only increase as long as new people are infected and the ones who are on treatment live longer.

Secondly, medical staff, especially nurses are hard to find (Frankish, 2005, personal comm., 26 Aug). Cape Town has been fortunate to attract medical staff to its urban clinics (Slingers, 2005, personal comm., 1 Sept). If medical staff is taken from other health services, this might create a backlash were other essential medical areas lack staff as ART jobs are more attractive with higher salaries. Workloads in ARV clinics might lead to increased stress as clinics reach maximum capacity due to high uptakes of ARV patients, which might cause medical staff to seek other less stressful jobs. This is particularly challenging for the more rural clinics. The Western Cape is fortunate to have and has great need for their partnership with ARK, which helps recruit staff. Without the continuing support from NGOs, once again, PAWC seems more fragile.

Thirdly, the province has relied on external funding from the Global Fund to finance a large share of the antiretroviral treatment rollout. As of current rules, the Global Fund only finances grants for a 5 year period. Since the fund is relativly new, no grants have reached this 5 year mark, and policies for continued funding have not yet been decided. In 2009, when the Western Cape Global Fund grant is at is 5 year mark, funding from the Global Fund will stop. As discussed above, the numbers of people needing treatment will keep increasing, so the need for more money to finance this upscale is essential. This funding will have to be secured through national funds if no more external funds become available, meaning that the Western Cape will then have to compete with other provinces to get sufficient funding.

Fourthly, as the Western Cape was the first government programme to put people on ARVs, it is likely that the province will experience an in creasing number of patients which develop drug resistance and/or need to change the drug combination due to complications, thus the need for the more expensive second line ARVs will keep increasing. This makes the financial implications mentioned above even more relevant. If half of the patients on ARVs will need the

more expensive second line ARVs, this will pose immense financial challenges for the province.

The fifth challenge is the role of nutrition in successful ARV treatment. Key personnel in PAWC have mentioned, in interviews, that they underestimated the importance of nutrition, and should have included nutrition in the Global Fund application (Frankish, 2005, personal comm., 26 Aug). Lack of proper nutrition effects the ARV treatment, and in poor areas like Khayelitsha PAWC could have provided food parcels to patients on ARVs. Naturally this is a logistical and financial challenge which needs to be highlighted.

As seen in the challenges mentioned above, PAWC faces a number of serious challenges for a successful long term integrated programme. Slingers (2005, personal comm., 1 Sept) commented that much of the Western Cape ARV management team's success up to date can be attributed to a focused team with a 'can do' spirit. She recalled how they approached challenges and worked hard to solve problems and challenges. For example, how they phoned up doctors and nurses and personally asked them to come and work at an ARV site. Cloete further reiterated how a management team handles problems and challenges can say a lot about how well functioning the management is.

'One of the key success factors for me is the manner in which we manage challenges' (Cloete, 2005, personal comm., 30 Aug)

As the previous chapter has mentioned, the management of the Global Fund grant in Western Cape has been hailed as one of the success factors. Much credit has been given to the leader, Dr Fareed Abdullah and his strong management team. As of January 13 2006 Dr Abdullah has resigned from his position (Keeton, 2006), leaving it to his team to follow up his successful leadership. The way the team manages challenges in the future will tell if the program is a long-term success.

Conclusion

Access to the life saving antiretroviral treatment has caused much controversy in South Africa, with more than 5.2 million South Africans affected with HIV/AIDS. South Africa ranks as the country with the highest number of people infected, and AIDS is the country's number one killer. Thus the arrival of antiretroviral treatment (ART) has given hope to millions of people living with HIV/AIDS.

This dissertation has shown that the Provincial Department of Health in Western Cape was one of the first to start providing ART in South Africa. In 2003 the department applied for external funding from the Global Fund to fight AIDS, Tuberculosis and Malaria. Having presented a successful proposal, the Western Cape was able to rapidly scale up their AIDS treatment though out the province by employing more people on the ART campaign. Through this campaign more than 11 000 people living with HIV/AIDS are now receiving ART with 2750 being funded by the Global Fund money. This success has resulted in the Western Cape rollout being refereed to by experts as the ARV success story of the country.

This dissertation has shown how the Global Fund grant has, in it first year, clearly meet and in some cases exceeded its targets on ARV treatment. The following key factors have been presented that have contributed to this success:

1. The Western Cape had an advantage over other provinces as a result of their progressive and committed management team.
2. Having already initiated the provision of antiretroviral drugs back in 1999 in order to prevent HIV positive women of transmitting the infection to their infants and coupled with the experience gained from the three years of ARVs pilot projects in Khayelitsha and in Gugulethu, this has enabled them to more easily expand the rollout to the rest of the Western Cape. This was assisted by the successful application of the Global Fund grant and national funds, which enable them to provide ARV treatment , thus creating the basis for a successful programme

Based on these factors and achievement in meeting targets and objectives it is considered a successful grant. This implies that the money from the Global Fund thus far has been wisely

spent. There is further evidence to support these finding and these can be seen by historic view of ARV treatment in Western Cape provided within the dissertation.

The Western Cape Provincial Government has shown the rest of South Africa, that providing antiretroviral treatment through the public health service is possible, both in rural areas and urban poor areas like Khayelitsha. Through the research process it has been identified that the Western Cape Global Fund grant in the first year of the grant is a successful grant. Other provinces could learn and benefit from the experience and approaches the Western Cape has taken. They too could apply for external funding for ARV provision to build a stronger treatment programme.

Based on the research it is the perception of most interviewed that the Western Cape Province has the best possible outlook for the grant in years to come. It will be interesting to monitor the success of the second year of the grant now that the Western Cape Provincial HIV/AIDS key leader, Dr Fareed Abdullah has resigned as of 13 January 2006. This will be of particular interest since the research has hailed Dr Abdullah as one of the key factors for the success of the grant. The true test will be to see if the remaining management team and new leader will be able to continue this success. Only time will tell.

Bibliography

Abdool Karim, S. S. 2005. Introduction. *In*: S.S Abdool Karim and Q. Abdool Karim, eds. *HIV/AIDS in South Africa*. Cape Town, South Africa: Cambridge University Press, 31-36.

Abdool Karim, Q. 2004. HIV Treatment in South Africa: Overcoming Impediments to Get Started. *The Lancet*. 363:1394.

Abdullah, F. 2005. The Complexities of Implementing Antiretroviral Treatment in the Western Cape Province of South Africa. *Development Update*: 245-264.

Baleta, A. 2003. South Africa approves plan for universal access to antiretrovirals. *The Lancet*, 362.

Barnett, T & Whiteside, A. 2002. *AIDS in the Twenty-First Century: Disease and Globalization.* New York: Palgrave, Macmillan,

Benetar, S. R. 2004. Health Care Reform and the Crisis of HIV and AIDS in South Africa. *New England Journal of Medicine,* 351 (1):81-92.

Beresford, B. 2002. The Heart of AIDS Protest. *Mail and Guardian*. 12 April: 6.

Boelaert, M. & van Damme, W. & Meessen, B. & van der Stuyft, P. 2002. The AIDS crisis, cost-effectiveness, and academic activism. *Journal of Tropical Medicine and International Health.* 7(12):1001–1002.

Brown, B. M. 2004, Measuring HIV/AIDS Stigma. Centre for Social Science Research University of Cape Town. *CSSR Working Paper* No. 74.

Brugha, R. & Zwi, A. 2003. Antiretroviral Treatment in Developing Countries: the peril of neglecting private providers. *British Medical Journal*, 326: 1382-1384.

Butler, A. 2004. *Contemporary South Africa*. New York: Palgrave, MacMillan.

Butler, A. 2005a. The Negative and Positive Impacts of HIV/AIDS on Democracy. *Journal of Contemporary African Studies*, 23 (1).

Butler, A. 2005b. South Africa's HIV/AIDS Policy, 1994-2004: How can it be explained? *African Affairs*, July.

Cabinet's Decision. 2003. *The Operational Plan for Comprehensive Care and Treatment for People Living with HIV and AIDS.* Issued by: Government Communication and Information System. [Online]. Available http://www.doh.gov.za/docs/pr/2003/pr1119.html [1 Nov 2004]

Campbell, C. 2003. *'Letting them die': How HIV/AIDS prevention programmes often fail.* South Africa: James Currey

Campbell, C. & Williams, B. 2001. Briefing: Riding the Tiger: Contextualizing HIV Prevention in South Africa. *African Affairs,* 100 (398): 135-140.

Cameron, E. 2003. The Dead Hand of Denialism, *Weekly Mail and Guardian*, 17 April.

Cameron, E. 2005. *Witness to AIDS*. Cape Town: Tafelberg publishers.

Coetzee, C. & Nattrass, N. 2004. Living on AIDS treatment: a socio-economic profile of Africans receiving antiretroviral therapy in Khayelitsha, Cape Town. *CSSR working paper.* No. 71. Centre for Social Science Research, University of Cape Town.

Coetzee, D. & Hilderbrand, K. & Boulle, A. & Draper, B. & Abdullah, F. & Goemaere, E. 2005. Effectiveness of the first district-wide programme for the prevention of mother-to-child transmission of HIV in South Africa. *Bulletin of the World Health Organization,* 83 (7)

Coetzee, D. & Hildebrand, K. & Boulle, A. & Maartens, G. & Louis, F. & Labatala, V. & Reuter, H. & Ntwana, N. & Goemaere, E. 2004a. Outcomes after two years of providing antiretroviral treatment in Khayelitsha, South Africa. *AIDS*, 18: 887-895

Coetzee, D. & Hilderbrand, K. & Goemaere, E. & Matthys, F. & Boelaert, M.2004b. Integrating tuberculosis and HIV care in the primary care setting in South Africa. *Journal of Tropical Medicine and International Health,* 9(6): 11–15.

Constitutional Court of South Africa, Minister of Health and Others v. Treatment Action Campaign and Others, Case CCT 8/02. 2002. [Online] Available at http://www.tac.org.za/Documents/MTCTCourtCase/ConCourtJudgmentOrderingMTCTP-5July2002.pdf [1 Nov 2004]

Creese, A. & Floyd, K. & Alban, A. & Guinness, L. 2001. Cost-Effectiveness of HIV/AIDS Interventions in Africa: a systematic review of the evidence. *The Lancet*, 359:1635-1642.

Cullian, K. 2002. *SA under pressure to release KZN AIDS grant*. [Online] Centre of the Study of AIDS, University of Pretoria. Available at http://csa.za.org/article/articleprint/119/-1/1/ [21 Nov 2005]

Cullian, K. 2003. *Global Fund delay costs lives.* [online] Centre of the Study of AIDS, University of Pretoria. Available at http://csa.za.org/article/articleprint/187/-1/1/ [21 Nov 2005]

Cummins, P. 2002. Access to Health Care in the Western Cape. *The Lancet*, 360:49-50.

Deane, N. 2005. The political history of AIDS treatment. *In*: S.S Abdool Karim and Q. Abdool Karim, eds. *HIV/AIDS in South Africa*. Cape Town, South Africa: Cambridge University Press, 538-547.

De Cock, K. & Mbori-Ngacha, D. & Marum, E. 2002. Shadow on the Continent: Public Health and HIV/AIDS in Africa in the 21st Century. *The Lancet*, 360.

Decosas, J. 2003. HIV Prevention and Treatment in South Africa: affordable and desirable. *The Lancet*, 361.

Department of Health. 2004. *Health Sector Strategic Framework 1999-2004* [Online] Available at http://www.doh.gov.za/docs/policy/framework/framewrk99-04.html [19 April 2004].

Department of Health. 1995. *HIV/AIDS and STD Programme 1995-1996.* Pretoria. South Africa.

Department of Health. 2002a. *Revising the enhanced response to HIV/AIDS and Tuberculosis in the public health sector – finding requirements, 2003/04-2004/05.* Pretoria. South Africa.

Department of Health. 2002b. *HIV/AIDS/STD Strategic Plan for South Africa: 2000-2005.* Pretoria. South Africa.

Department of Health. 2003a. *Tracking progress on the HIV/AIDS and STI Strategic Plan for South Africa. Pretoria.* [Online]. Available at: http://www.doh.gov.za/aids/docs/progress.html (19 November 2005).

Department of Health. 2003b. *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.* Pretoria. South Africa.

Department of Health. 2003c. *National Department of Health Strategic Plan, 2003/4 to 2005/6.* Pretoria. South Africa.

Department of Health. 2004a. *Monitoring and Evaluation Framework for the Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.* Pretoria. South Africa.

Department of Health. 2004b. *Monitoring Review: Progress Report on the Implementation of the Comprehensive HIV and AIDS Care, Management and Treatment Program.* Pretoria. South Africa.

Department of Health. 2004c. *National Antiretroviral Treatment Guidelines.* Pretoria. South Africa.

Department of Health. 2004d. *Strategies Priorities for the National Health System: 2004-2009.* Pretoria. South Africa.

Department of Health. 2005. *National HIV and syphilis antenatal sero-prevalence survey in South Africa 2004.* Pretoria. South Africa.

Dorrington, R. & Bourne D. & Bradshaw. D. & Laubscher. R. & Timæus, I. 2001. *The Impact of HIV/AIDS on Adult Mortality in South Africa.* Technical Report, Burden of Disease Research Unit, Tygerberg: Medical Research Council, September.

Egger, M. & Boulle, A. & Schechter, M. & Miotti, P. 2005. Antiretroviral therapy in resource-poor settings: scaling up inequalities? *International Journal of Epidemiology*, 34: 509–512

Epstein, H. 2003. AIDS in South Africa: The Invisible Cure. *New York Review of Books*, 50 (11).

Farmer, P. & Landre, F. & Mukherjee, J. & Sidonise Claude M. & Nevil, P. & Smiht-Fawzi, M. & Koenig, S. & Castro, A. & Becerra, M. & Sachs, J. & Attaran, M. &Yong Kim, J. 2001. Community-Based Approaches to HIV treatment in resource-poor settings. *The Lancet*, 358.

Fassin, D. & Schneider, H. 2003. The Politics of AIDS in South Africa: Beyond the Controversies. *British Medical Journal*, 326: 495-498.

Ford, N. 2004. Patents, Access to Medicines and the Role of Non-Governmental Organizations. *Journal of Generic Medicines*. 1 (2): 137-145.

Galvão, J. 2002. Access to antiretroviral drugs in Brazil. *The Lancet*, 360.

Geffen, N. & Nattrass, N. & Raubenheimer C. 2003. The Cost of HIV/AIDS Prevention and Treatment Interventions. *CSSR Working Paper*. No 29. Centre for Social Science Research. University of Cape Town

Gibson, D. 2004. The gaps in the gaze in South African hospitals. *Social Science & Medicine*, 59:2013–2024

The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2004a. *Grant Agreement SAF-304-G04-H Strengthening and expanding the Western Cape HIV/AIDS prevention, treatment and care programme*. Geneva, Switzerland.

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2004b. *A Force for Change: the Global Fund at 30 months*. Geneva, Switzerland.

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2004c. *Annual Report 2003*. Geneva, Switzerland.

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005a. Annual Report 2004. [Online] Geneva, Switzerland. Available at http://www.theglobalfund.org/en/ [6 Jan 2006]

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005b. *Phase 2 Q&A*. [online] Available at www.theglobalfund.org/en/files/funds_raised/performance/phase2_qa.pdf [21 Nov 2005]

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005c. *Current Funding Rounds*. [Online] Available at http://www.theglobalfund.org/en/apply/current/#1 [21 Nov 2005]

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005d. Global Fund website.

[online] Available at http://www.theglobalfund.org/en/ [21 Nov 2005]

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005e. *History of the fund in details.* [Online] Available at http://www.theglobalfund.org/en/about/road/history/default.asp [21 Nov 2005]

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005f. *Search programs.* [Online] Available at http://www.theglobalfund.org/search/default.aspx?lang=en&round=3

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005g. *Investing in the Future: The Global Fund at Three Years.* Geneva, Switzerland.

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005h. *Addressing HIV/AIDS, Tuberculosis and Malaria: The Resource Needs of the Global Fund 2005-2007.* Geneva, Switzerland.

The Global Fund to fight AIDS, Tuberculosis and Malaria. 2005i. *HIV/AIDS, Tuberculosis and Malaria: The Status and Impact of the Three Diseases.* Geneva, Switzerland

The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2006. *Portfolio of Grants in South Africa.* [Online] Available at: http://www.theglobalfund.org/search/portfolio.aspx?lang=en&countryID=saf [6 Jan 2006]

Gouws, E. & Abdool Karim, Q. 2005. HIV infection in South Africa: the evolving epidemic. *In*: S.S Abdool Karim and Q. Abdool Karim, eds. *HIV/AIDS in South Africa.* Cape Town, South Africa: Cambridge University Press, 48-66.

Grimwood, A. & Crewe, M. & Betteridge, D. 2000. HIV/AIDS – Current issue. [Online] *South African Health Review.* Durban: HST: 287-299. Available at: http://www.hst.org.za/uploads/files/chapters14_00.pdf [1 AUG 2005]

Guthrie, T. & Hickey, A. (Eds). 2004. *Funding the Fight: Budgeting for HIV/AIDS in Developing Countries.* Cape Town: AIDS Budget Unit, IDASA.

Herman, D. 2006. Cape loses top fighter against AIDS as Abdullah resigns post. *Cape Times.* January 9.

Heywood, M. 2004. The Price of Denial. *Development Update*, 5 (3): 93-122.

Heywood, M. 2005. The Achilles heel? The impact of HIV/AIDS on democracy in South Africa. *In*: S.S Abdool Karim and Q. Abdool Karim, eds. *HIV/AIDS in South Africa.* Cape Town, South Africa: Cambridge University Press, 371-383.

Horton, R. 2000. African AIDS beyond Mbeki: Tripping into Anarchy. *The Lancet*, 356:1541-2.

Hosseinipour, M. & Kazembe, P. & Sanne, I & van der Horst, C. 2002. Challenges in delivering antiretroviral treatment in resource poor countries. *AIDS,* 16(4):S177–S187

Jones, P. 2005. A Test of Governance: rights-based struggles and the politics of HIV/AIDS policy in South Africa. *Political Geography,* 24:419–447.

Jones, P. 2004. Of Gifts and Return Gifts: Beyond the Political and Practical Deficits of Donor Assistance. *Development Update*, 5(3):157-182.

Jubasi, M. 2002. Health Minister lashes UN Aids fund. [Online] *Sunday Times*. Available at http://www.suntimes.co.za/2002/07/21/news/news02.asp [5 April 2005]

Kapp, C. 2004 Antiretrovirals give new hope and new life to South Africans. *The Lancet*, 363.

Kasper, T. & Coetzee, D. & Boulle, A. & Hilderbrand, K. 2003. Demystifying antiretroviral therapy in resource-poor settings. *Essential Drugs Monitor*, 32:20-21.

Kauffman, K. D. & Lindauer, D. L. (Eds). 2004. *AIDS and South Africa: The Social Expression of a Pandemic.* New York: Palgrave Macmillan.

Keeton, C. 2006. Top AIDS doctors join exodus from state service. *Cape Times*. 8 January.

Kober, K & Wim Van Damme. 2004. Scaling Up Access to Antiretroviral Treatment in Southern Africa: Who Will Do the Job? *The Lancet*, 364:103-107.

Koenig, S. & Le´andre, F. & Farmer, P.2004. Scaling-up HIV treatment programmes in resource limited settings: the rural Haiti experience. *AIDS*, 18 (3):S21–S25

Kovsted, J. 2005. Scaling Up AIDS Treatment in Developing Countries: A Review of Current and Future Arguments. *Development Policy Review*, 23 (4):465-482

Loewenson, R. & McCoy, D. 2004. Access to antiretroviral treatment in Africa. *British Medical Journal,* 328:241-242

Marseille, E. & Hofmann, P. B. & Kahn, J. G.2002. HIV prevention before HAART in sub-Saharan Africa. *The Lancet*, 359.

Marshall, S.J. 2004. South Africa Unveils National HIV/AIDS Treatment Programme. *Bulletin of the World Health Organization,* 82(1):73-74.

Matters, R. 2002. Examining HIV/AIDS in Southern Africa through the eyes of ordinary Southern Africans. *CSSR Working Paper.* No.11. University of Cape Town

McCoy, D. 2005. Expanding treatment access and strengthening HIV/AIDS programmes in ways that strengthen the broader health systems agenda: Issues for the Global Fund to Fight HIV/AIDS, TB and Malaria. *AIDS Bulletin*, 14(1)

McCoy, D. & Chopra, M. & Loewenson, R. & Aitken, J. M. & Ngulube, T. & Muula A. & Ray, S.& Kureyi, T. & Ijumba, P. & Rowson, M. 2005. Expanding Access to Antiretroviral Therapy in Sub-Saharan Africa: Avoiding the Pitfalls and Dangers, Capitalizing on the Opportunities. *Global Health Concerns*, 95(1):18-22.

MRC Burden of Disease Unit & Metro Information Group & University of Cape Town's Department of Public Health & University of Western Cape's School of Public Health. 2005. *Causes of death and premature mortality in Cape Town.*

Médecins Sans Frontières & Infectious Disease Epidemiology Unit, University of Cape Town. 2003. *Providing Antiretroviral Therapy at Primary Health Care Clinics in Resource Poor Settings, The experience from Khayelitsha' Activity Report 2003.*

Médecins Sans Frontières & The Department of Public Health at the University of Cape Town & the Provincial Administration of the Western Cape. 2003. *Antiretroviral therapy in Primary Health Care: The experience from Khayelitsha Programme in South Africa.* World Health Organisation. Geneva.

Mills, A. 2005. Mass campaigns versus general health services: What have we learnt in 40 years about vertical versus horizontal approaches? *Bulletin of the World Health Organization,* 83(4).

Mills, A. & Palmer, N. &Gilson, L. & McIntyre, D. & Schneider, H. & Sinanovic, E. & Wadee, H. 2004. The performance of different models of primary care provision in Southern Africa. *Social Science & Medicine*, 59:931–943.

Morris, L. & Cilliers, T. 2005. Viral structure, replication, tropism, pathogenesis and natural history. *In*: S.S Abdool Karim and Q. Abdool Karim, eds. *HIV/AIDS in South Africa.* Cape Town, South Africa: Cambridge University Press, 79-88.

Nattrass, N. 2001. Ethics, Economics and AIDS Policy in South Africa. *CSSR Working Paper.* No. 1. Centre for Social Science Research, University of Cape Town.

Nattrass, N. 2003. Unemployment and AIDS: The Social-Democratic Challenge for South Africa. *Forum 2003 papers.* Development Policy Research Unit, School of Economics, University of Cape Town.

Nattrass, N.2004. *The Moral Economy of AIDS in South Africa.* Cambridge University Press.

Nattrass, N. 2005. AIDS, Inequality and Access to Antiretroviral Treatment: An Exploratory Comparative Analysis. *CSSR Working Paper.* No. 117 Cape Town: Centre for Social Science Research

Nattrass, N. & Geffen, N. 2004 *The Impact of Reduced Drug Prices on the Cost-Effectiveness of HAART in South Africa.* Research Summary. Centre for Social Science Research, University of Cape Town.

Oliveira-Cruz, V. & Kurowski, C. & Mills, A.2003. Delivery of Priority Health Services: Searching for synergies within the vertical versus horizontal debate. *Journal of International Development*, 15:67–86.

Ooms, G. & Schrecker, T. 2005. Expenditure ceilings, multilateral financial institutions, and the health of poor populations. *The Lancet*, 365.

Orrell, C. & Bangsberg, D. R. & Badri, M. &Wood, R. 2003. Adherence is not a barrier to successful antiretroviral therapy in South Africa. *AIDS*, 17:1369–1375.

Orrell, C. & Bekker, L. G. & Wood, R. 2001. Adherence to Antiretroviral Therapy – Achievable in the South African Context? *South African Medical Journal*, 91(6):484

Parker, R. & Aggleton, P. 2003. HIV and AIDS-related Stigma and Discrimination: a conceptual framework and implications for action. *Social Science and Medicine*, 57(1):13-24.

Pawinski, R. & Lalloo, U & Jinabhai, C. & Bobat, R. 2002. Community-based approach to HIV treatment. *The Lancet*. 359.

Petersen, I. & Swartz, L. 2002. Primary Health Care in the Era of HIV/AIDS: Some Implications for Health Systems Reform. *Social Science and Medicine*, 55(6):1005-1013.

Provincial Administration of the Western Cape: Department of Health, 2002. *The Provincial & District HIV Antenatal Survey 2001.*

Provincial Administration of the Western Cape, Department of Health and the Provincial AIDS Council. 2003a. *Proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria.*

Provincial Administration of the Western Cape, Department of Health. 2003b. *The Provincial & District HIV Antenatal Survey 2002.*

Provincial Government of Western Cape. 2003c. *Global Fund Aids Breakthrough for Province.* [Online] Office of Western Cape Premier, Statement by Western Cape Premier, Marthinus van Schalkwyk, (17 November 2003) Available at www.capegateway.gov.za/eng/pubs/news/2003/nov/53082 [8 April 2005]

Provincial Administration of the Western Cape, Department of Health. 2004a. *The Provincial & District HIV Antenatal Survey 2003.*

Provincial Administration of the Western Cape, Department of Health, 2004b. *Annual Report 2003/2004.*

Provincial Administration of the Western Cape, Department of Health. 2004c. *Global Fund work plan.* (Unpublished)

Provincial Administration of the Western Cape, Department of Health. 2004d. *Global Fund Monitoring and Evaluation plan.* (Unpublished)

Provincial Administration of the Western Cape, Department of Health. 2005a. *The Provincial & District HIV Antenatal Survey 2004.*

Provincial Administration of the Western Cape, Department of Health. 2005b. *Six-month*

Progress Report: 1 July - 31 December 2004 Global Fund Grant Agreement SAF-304-G04-H. (Unpublished)

Provincial Administration of the Western Cape, Department of Health. 2005c. *Six-month Progress Report: 1 January – 30 June 2005 Global Fund Grant Agreement SAF-304-G04-H.* (Unpublished)

Provincial Administration of the Western Cape, Department of Health & City of Cape Town Health Services & Médecins Sans Frontières & Infectious Disease Epidemiology Unit, University of Cape Town. 2005. *Comprehensive HIV Service Development at Primary Care Clinics – The experience from Khayelitsha; Activity update July 2005.*

Robins, S. 2004. 'Long Live Zackie, Long Live': AIDS Activism, Science and Citizenship after Apartheid. *Journal of Southern African Studies*. 30(3).

Rosen, S. & Sanne, I. & Collier A. & Simon, J.2005. Hard Choices: Rationing Antiretroviral Therapy for HIV/AIDS in Africa. *The Lancet*, 365:354-356.

Rosenberg, R. 2005. Medical charity to hold on to city HIV clinics until 2007. *Cape Times*, 17 November.

Schneider, H. 2002. On the Fault-Line: The Politics of AIDS Policy in Contemporary South Africa. African Studies 61(1):145-167.

Schneider, H. (ed.) 2003. *Scaling up the use of Antiretrovirals in the Pubic Health Sector: What are the challenges?* Proceedings of a seminar hosted by the School of Public Health and the Perinatal HIV Research Unit, University of the Witwatersrand, 1 August.

Schneider H. & Coetzee D. 2003. Strengthening the health care system and ensuring equity in the wide scale implementation of an antiretroviral therapy programme in South Africa. *South African Medical Journal*, 93:772-773.

Schneider, H. & Fassin, D. 2002. Denial and Defiance: A Socio-Political Analysis of AIDS in South Africa. *AIDS*, 16(4):S45-51.

Schneider, H. & Stein, J. 2001. Implementing AIDS Policy in Post-Apartheid South Africa. *Social Science and Medicine*, 52 (5):723-731.

Scott, V. E. & Chopra, M. & Conrad, L. & Ntuli, A. 2005. How equitable is the scaling up of HIV service provision in South Africa? *South African Medical Journal*, 95(2)

von Schoen Angerer, T. & Wilson, D. & Ford, N. & Kasper, T. 2001. Access and activism: the ethics of providing antiretroviral therapy in developing countries. *AIDS*, 15(5):S81-S90.

Sidley, P. 2003. Cabinet rules that South Africans must be given Antiretrovirals. *British Medical Journal*, 327:357

Singh, J. 2004. Standards of Care in the Antiretroviral Rollout World. *The Lancet,* 364:920-922.

Statistics South Africa. 2003. *Census 2001.*

Stein, J. 2005. The impact of antiretroviral (ARV) provision on HIV/AIDS prevention. *AIDS Bulletin,* 14(1).

Stewart, R. & Loveday, M. 2005. *Public HAART Projects in South Africa – Progress to November 2004.* Health Systems Trust, Durban.

Stewart, R. & Padarath, A. & Bamford, L. 2004. *Providing Antiretroviral Treatment in Southern Africa: A Literature Review.* Health Systems Trust.

Stilwaggon, E. 2002. HIV/AIDS in Africa: Fertile Terrain. *The Journal of Development Studies,* 38(6):1-22.

Thom, A. 2003. *KZN to get Global Fund money by April.* [Online] Centre of the Study of AIDS, University of Pretoria. Available at http://csa.za.org/article/articleprint/176/-1/1/ [21 Nov 2005]

Thom, A. 2004. *Western Cape starts spending AIDS money.* [Online] Centre of the Study of AIDS: South Africa. Available at www.csa.za.org/article/articleview/327/1/1/ [8 April 2005]

Thom, A. 2005. *Western Cape leads the way.* [Online] Centre of the Study of AIDS: South Africa. Available at http://www.csa.za.org/article/articleview/364/1/1/ [1 AUG 2005]

United Nations. 2001. *Secretary-General proposes global fund for fight against AIDS and other infectious diseases at African Leaders Summit.* [Online] Press release, SG/SM/7779/Rev.1 26/04/2001. Available at http://www.un.org/News/Press/docs/2001/SGSM7779R1.doc.htm [6 Jan 2006]

UNAIDS. 2005. *Epidemic Update December 2005.* [Online] Geneva, Switzerland. Available at www.unaids.org [1 Dec 2005]

Usdin, S. 2003. *The no-nonsense guide to HIV/AIDS.* Oxford: New Internationalist

Van der Vliet, V. 2001. AIDS: Losing the 'New Struggle'? *Daedalus.* 130 (1):151-184.

Van der Vliet, V. 2004. South Africa divided against AIDS: a crisis of leadership. *In* Kaufman, K. D & Lindauer, D. L., *Eds. AIDS and South Africa – The Social Expression of a Pandemic.* New York: Palgrave Macmillan. 48-93.

De Waal, A. 2000. *AIDS: Africa's Greatest Leadership Challenge.* Justice Africa. Available at www.justiceafrica.org/aidspaper.htm [5 April 2005]

Walker, L. & Reid, G. & Cornell, M. 2004. *Making it happen – HIV/AIDS in South Africa.* Colorado: Lynne Rienner Publishers.

Whiteside, A. & Sunter, C. 2000. *AIDS: the Challenge for South Africa.* Tafelberg Publishers. Cape Town:

Whiteside, A. & Mattes, R. & Willan, S. & Manning, R. 2002. Examining HIV/AIDS in Southern Africa through the Eyes of Ordinary South Africans. CSSR Working Paper 11, Centre for Social Science Research, University of Cape Town. Available on www.uct.ac.za/depts/cssr.

Wood, R. 2005. Antiretroviral therapy. *In*: S.S Abdool Karim and Q. Abdool Karim, eds. *HIV/AIDS in South Africa.* Cape Town, South Africa: Cambridge University Press, 504-523.

Worden, N. 1994. *The Making of Modern South Africa: Conquest, Segregation, and Apartheid.* Oxford: Blackwell Publishers.

World Health Organisation. 2003. Antiretroviral therapy in primary health care: Experience of the Khayelitsha programme in South Africa. Case Study. Perspectives and Practice in Antiretroviral Treatment.

World Health Organisation. 2003. *Treating 3 Million by 2005: Making it Happen.* [Online] Available at www.who.int/3by5/en/ [1 AUG 2005]

World Health Organisation. 2005. "3 by 5 Progress Report. [Online]. Available at: http://www.who.int/3by5/en/Progressreport.pdf [1 AUG 2005]

Zapiro. 2000. Pres. Mbeki's select advisory panel of international AIDS experts. *Weekly Mail & Guardian.* Comic illustration. 16 March.

Zapiro.2005. Tshabalala-Mismang. *Weekly Mail & Guardian.* Comic illustration. 24 November

Appendix: A - List of ARV sites in the Western Cape per July 2005

ARV sites in Western Cape pr. July 2005; the highlighted ones are supported by money from the Global Fund to fight AIDS, Tuberculosis and Malaria.

1. Groote Schuur Hospital	2. Tableview
3. Red Cross Hospital	4. Cloetesville DH
5. Tygerberg Hospital	6. Swartland
7. G.F. Jooste Hospital	8. TC Newman Hospital
9. Hottentots Holland Hospital	10. Vredenberg
11. Victoria Hospital	12. Vredendahl
13. Guguletu CHC	14. Citrusdahl
15. Masiphumelele Clinic	16. Ceres Hospital
17. Michael M CHC	18. Eben Donges Hospital
19. Nolungile CHC	20. Grabouw
21. Site B, Khayelitsha CHC	22. Hermanus
23. Crossroads	24. Robertson
25. Eersterivier	26. Swellendam
27. Kraaifontein	28. Beaufort West Hospital
29. Mitchells Plain CHC	30. George Hospital
31. Robbie Nurrock	32. Knysna
33. Westfleur Hospital	34. Mosselbaai
35. Hout Bay Clinic	36. Oudtshoorn
37. Langa Clinic	

Appendix: B - Interviews and personal communication

Person	Date
Fareed Abdullah	19 July 2005
	20 July 2005
	23 Sept 2005
Andrew Boulle	10 August 2005
Liezl Channing	25 August 2005
Keith Cloete	30 August 2005
John Frankish	22 July 2005
	26 August 2005
Eric Goemaere	5 August 2005
Gray Maartens	4 August 2005
Pren Naidoo	1 August 2005
Nevilene Slingers	1 September 2005
Ivan Toms	23 August 2005
Robin Wood	9 September 2005

*Appendix: C - Global Fund to fight AIDS, Tuberculosis and Malaria – Board members**

*As per 28.January 2006 according to the Global Fund's website
http://www.theglobalfund.org/en/about/board/members/

Voting Board Members

Canada (Germany & Switzerland)
Dr. Ernest Loevinsohn
Director General
Program Against Hunger, Malnutrition and Disease
Canadian International Development Agency
Canada

Communities (NGOs representative of the Communities Living with the Diseases)
Ms. Anandi Yuvaraj
Program officer of India HIV/AIDS Alliance
India

Developed Country NGO
Mr. Peter van Rooijen
Stop AIDS Now!
The Netherlands

Developing Country NGO
Ms. Rita Arauz Molina
President
Fundacion Nimehuatzin
Nicaragua

Eastern Europe (Romania)
Mr. Eugen Nicolaescu
Minister of Health
Romania

Eastern Mediterranean Region
Mr. Abdullah Abdillahi Miguil
Minister of Health
Djibouti

Eastern and Southern Africa (Angola)
Dr. Jose Viera Dias Van D?/a>
Deputy Minister of Health
Angola

European Commission (Austria, Belgium)
Dr. Lieve Fransen
Head of Unit
Human and Social Development
European Commission
Belgium

France (Luxemburg, Spain)
Prof. Serge Tomasi
Ministry of Foreign Affairs
France

Italy
Mr. Giuseppe Deodato
Director-General Development Cooperation
Ministry of Foreign Affairs
Italy

Japan
Mr. Masaru Tsuji
Deputy Director General
Global Issues Department
Ministry of Foreign Affairs
Japan

Latin America and Caribbean (Barbados) - Chair of the Board
Dr. Carol Jacobs
Chairman National HIV/AIDS Commission
Prime Minister's Office

Vice-Chair of the Board
VACANT

Point Seven (Sweden - Denmark, Ireland, Netherlands, Norway)
Mr. Carsten Staur
State Secretary, Ambassador
Ministry of Foreign Affairs
Denmark

Private Foundations
Dr. Helene D. Gayle
Director, HIV, TB and Reproductive Health
Bill and Melinda Gates Foundation Executive Offices
USA

Private Sector
Mr. Rajat Gupta
Senior Director
McKinsey & Company
USA

South East Asia (India)
Dr. Anbumani Ramadoss
Union Minister for Health and Family Welfare
India

United Kingdom (Australia)
Dr. Carole Presern
United Kingdom

USA
VACANT

West and Central Africa (Cameroon)
Mr. Urbain Olanguena Awono
Minister of Public Health
Ministry of Health
Cameroon

Western Pacific Region (China)
Dr. Huang Jiefu
Vice-Minister

Ministry of Health
China

Ex Officio Members without voting rights

UNAIDS
Dr. Peter Piot
Executive Director
UNAIDS
Switzerland

WHO
Dr. Jong-Wook Lee
Director-General
WHO
Switzerland

WORLD BANK
Mr. Geoffrey Lamb
Vice President Concessional Finance and Global Partnerships
World Bank
USA

Board Designated non voting Swiss Member
Mr. Edmond Tavernier
Senior Partner
Tavernier Tschanz (Avocates: Attorneys-at-Law)
Switzerland

Appendix: D - List of ARVs stocked in the ARV depot as per April 2005.

DESCRIPTION	TRADE NAME	STRENGTH	COMPANY	QTY
Stavudine (D4T)	ZERIT CAPS	20mg	BMS	56
		30mg	BMS	56
		40mg	BMS	56
	ZERIT SOLN	1mg/ml	BMS	200ml
Abacavir	ZIAGEN TABS	300mg	GSK	60
	ZIAGEN SOLN	20mg/ml	GSK	240ml
Didanosine (DDI)		25mg	ASPEN	60
		50mg	ASPEN	60
		100mg	ASPEN	60
		150mg	ASPEN	60
Zidovudine (AZT)	ASPEN ZIDOVUDINE	10MG/ML	ASPEN	200ML
	ASPEN ZIDOVUDINE	300MG	ASPEN	60
(NVP)	ASPEN NEVIRAPINE	200MG	ASPEN	60
AZT/3TC	LAMZID	300/150mg	ASPEN	60
Ritonavir	NORVIR CAPS	100mg	Abbott	84
	NORVIR SYRUP	80mg/ml	Abbott	90 ml
Stavudine (D4T)	ZERIT CAPS	20mg	BMS	56
		30mg	BMS	56
		40mg	BMS	56
	ZERIT SOLN	1mg/ml	BMS	200ml
Stavudine (D4T)	ASPEN STAVUDINE	20mg	ASPEN	60
	ASPEN STAVUDINE	30mg	ASPEN	60
	ASPEN STAVUDINE	40mg	ASPEN	60
Stavudine (D4T)	STAVIR	30mg	CIPLA	60
	STAVIR	40mg	CIPLA	60
Zidovudine (AZT)	RETROVIR CAPS	100mg	GSK	100
	RETROVIR TABS	250mg	GSK	60
	RETROVIR CAPS	300mg	GSK	60
	RETROVIR IV		GSK	20 ml (5)
	RETROVIR SYR	10mg/ml	GSK	200 ml
Zidovudine (AZT)	ASPEN ZIDOVUDINE	10MG/ML	ASPEN	200ML
	ASPEN ZIDOVUDINE	300MG	ASPEN	60

DESCRIPTION	TRADE NAME	STRENGTH	COMPANY	QTY
Lamivudine (3TC)	3TC TABS	150mg	GSK	60
	3TC SYRUP	10mg/ml	GSK	240 ml
Stavudine (D4T)	ASPEN STAVUDINE	20mg	ASPEN	60
	ASPEN STAVUDINE	30mg	ASPEN	60
	ASPEN STAVUDINE	40mg	ASPEN	60
AZT/3TC	COMBIVIR TABS	300/150mg	GSK	60
ritonavir (LPV/r)	KALETRA CAPS	133/33	Abbott	2x90
	KALETRA SYR	80/20	Abbott	5x60ml
Ritonavir	NORVIR CAPS	100mg	Abbott	84
	NORVIR SYRUP	80mg/ml	Abbott	90 ml
Zidovudine (AZT)	RETROVIR CAPS	100mg	GSK	100
	RETROVIR TABS	250mg	GSK	60
	RETROVIR CAPS	300mg	GSK	60
	RETROVIR IV		GSK	20 ml (5)
	RETROVIR SYR	10mg/ml	GSK	200 ml
Stavudine (D4T)	STAVIR	30mg	CIPLA	60
	STAVIR	40mg	CIPLA	60
Efavirenz	STOCRIN CAPS	50mg	MSD	30
	STOCRIN CAPS	200mg	MSD	90
	STOCRIN TABS	600MG	MSD	30
Nevirapine (NVP)	VIRAMUNE TABS	200mg	B Ingelheim	60
	VIRAMUNE SYR	10mg/ml	B Ingelheim	240 ml
Didanosine (DDI)	VIDEX TABS	25mg	BMS	60
	VIDEX TABS	50mg	BMS	60
	VIDEX TABS	100mg	BMS	60
	VIDEX TABS	150mg	BMS	60
	VIDEX PWD	2g	BMS	1