

Death by Delay – The Moratorium on ARV initiation at Edendale Hospital (May – July 2009)

“I regret going to test. It is better to live not knowing you are sick if you are not going to get help. My mother is saying if I did not test I would not be so anxious, I would be feeling better.”

Elizabeth Lesedi*, seasonal plantation worker and mother of three

In 2009 the AIDS Law Project investigated the Edendale Hospital Moratorium following press reports from Health-e news and others, and a call from a concerned private practitioner in Pietermaritzburg.

This report is compiled from press reports, interviews and documents from patients and health care workers from mid-June to August 2009. The identities of some interviewees have been kept confidential to protect their privacy.

The AIDS Law Project thanks the Treatment Action Campaign, and the doctors and patients at the Edendale Hospital for their co-operation.

EXECUTIVE SUMMARY

High numbers of patients

Edendale is part of health district 22, or uMgungundlovu District, and serves about 1 million people. There are three hospitals, Edendale Hospital which serves about 800 000 people, Northdale Hospital which serves about 200 000 people and a tertiary referral hospital, Grey's Hospital. Also in the area are two major tuberculosis hospitals, Doris Goodwin Hospital, next to Edendale Hospital, and Richmond Chest Hospital. These hospitals are supported by 17 fixed community clinics and six mobile clinics, making 23 in all.

High rates of HIV prevalence

According to the Edendale Hospital records, the HIV infection rate recorded in the antenatal clinic from women undergoing voluntary testing and counselling was about 60% from 2005 until 2008, and only in 2009 did that rate drop to less than 50%. During this period the estimates for the District from the Department of Health were about 44% for rates of infection recorded in antenatal clinics. These prevalence rates are some of the highest in South Africa.

Galloping need for ART

The 860-bed hospital started to provide antiretroviral treatment (ARVs) in 2004. From 3000 patients on ARVs in 2006, by May 2009 it already had almost 11000 patients on ARVs. The waiting list for initiation onto ARVs grew from 297 in early 2007 to over 2000 people by July 2009.

Poor planning, budgeting, human resource management and communication by Department of Health

Despite 30 letters over three years from Edendale Hospital managers, and about 12 meetings with District and Provincial staff from the Department of Health (*see Appendix 1*), the hospital continued to experience severe shortages of doctors, nurses, pharmacists and related staff, inadequate space to see patients and issue drugs, and inability to expand access to PEP for rape survivors and follow-up more effectively on infants exposed to infection

Complete suspension of ART initiation and unnecessary deaths

The escalating shortage of staff and space led to a total suspension of ARV initiation from 6 May 2009 to 20 July 2009, resulting in several known (and probably several more not yet recorded) unnecessary deaths for patients, some of whom had already been on the waiting list for life-saving treatment for up to nine months with CD4 counts as low as 13.

Only press exposure and public protests led to an emergency response by Department of Health

After a series of press reports since 15 June 2006, and public protests including a vigil and a march, the new Member of the Executive Council for the Department of Health at last responded on an emergency basis to develop a rescue plan with the doctors at Edendale Hospital. The Umgungundhlovu District Manager was first dismissed, then reinstated and offered a transfer, and subsequently resumed her post in the same District.

Patients angry, despairing and dying

Patients interviewed said they had felt they should never have tested, or there was no point in continuing to live disabled, or expressed such anger at their inability to access health services that they reportedly caused a counselor to resign, and many staff at the clinics and hospital need trauma and depression counseling to continue to work in these circumstances.

More permanent solution needed

Some relief was afforded through interim funding for sessional doctors and pharmacists, NGO intervention on patient data management, approval of nine new doctor/pharmacist posts, renovation of the hospital pharmacy, and a pilot project for a initiation team to visit clinics. This was too late for some patients, and is too little to meet even the current needs.

The doctors have appealed in a memorandum invoking the Constitutional duty of the Department of Health to have a rational plan to provide for the progressive realization of the right to access to health services, for better planning and communication regarding how to address the ongoing need for more staff, more space, more equipment and better records management facilities to meet the rapidly expanding need for ARV treatment in the District. Otherwise a new crisis looms.

What is in this report

This report is divided into five sections:

- **Section One – Suspension of ARV initiation leads to ill-health and death:** The impact of the hospital's decision to suspend starting new patients on antiretroviral treatment caused extreme distress and resulted in death for patients on the waiting list. We also set out some issues hampering anti-retroviral rollout at Edendale Hospital.
- **Section Two - No adequate response from Province until service breaks down completely:** The hospital's antiretroviral treatment staff asked for help from the KwaZulu-Natal Provincial and Umgungundlovu District Department of Health over three years, in letters and meetings. It took a complete breakdown of ARV initiation services to trigger a response from the District and the Province to what had by then become an emergency. This could have been avoided by responding earlier.
- **Section Three - Ongoing shortage of pharmacists, doctors, nurses and support staff:** Despite ongoing submission of requests, plans and organograms for more staff, the hospital had so few staff to meet the ARV rollout need that finally after a prolonged period of overstrain and no over-time, the existing staff were not able to cope with any new patients without jeopardizing care to existing patients. Patients already on a waiting list were told they would have to carry on waiting for treatment, and some died. Despite the provision of temporary staff and interim funding, the new posts have not yet been filled and the shortage remains.
- **Section Four - Ongoing lack of space and equipment:** the second main cause of the suspension of ARV initiations at Edendale Hospital this year was the lack of space and facilities. The waiting room was so small that patients had to wait outside and two doctors had to consult in one room. The pharmacy was so small the pharmacists and drugs could hardly fit inside. Patient information was not accessible and there was no space or resources for adequate data management. This effectively meant that more time was already taken from an already overloaded healthcare staff. Finally there is an urgent need for additional support such as space for social workers and equipment such as computers.
- **Section Five – Lack of planning and poor communication:** The KwaZulu-Natal Provincial and Umgungundlovu District Department of Health failed to respond in time despite long-term warning of the developing crisis over three years in over 30 letters and 12 meetings. There is a need for better joint planning with the ARV rollout staff at the hospital and more efficient channels of communication.

SECTION ONE: Impact of the ARV initiation suspension

In this section, the report covers the growth of the waiting list for initiation onto antiretroviral treatment. It then sets out some of the consequences for patients, of Edendale Hospital's decision to completely suspend initiation onto antiretroviral therapy for patients on the waiting list, for ten and a half weeks in mid-2009. These consequences range from death, narrow escapes from likely death, to despair, apathy and high levels of anxiety and daily deteriorating health (including ongoing diarrhoea, weight loss and coughing for thousands of people).

The report also covers the increased impact of illness on the patients and their families through losing jobs and poverty, the burnout of staff at the hospital, the tensions that developed around treatment delay, and a lack of information, in the community.

Waiting list grows

The rollout of antiretroviral treatment started at Edendale Hospital in 2004, at Richmond Chest Hospital's iThemba clinic in 2006 and at Richmond Clinic in 2007. However, by 2007, the number of patients in need of antiretroviral treatment began to outstrip the capacity to initiate new patients and resulted in the development of a waiting list for beginning antiretroviral treatment. This waiting list grew from about 297 patients in 2007, to approximately 450 people in May 2009.

According to a doctor at Edendale Hospital, by 18 December 2008, the adult clinic was running to capacity with 11 000 patients on ARV treatment and could not take on new patients. In addition, the number of pregnant women taking ARVs for the Prevention of Mother To Child Transmission (PMTCT) was increasing. Each doctor was seeing 25-30 patients a day in addition to unscheduled acutely ill patients. There were 400 patients on the waiting list, 100 of which had a CD4 count of less than 100. To handle the new cases and do proper follow-up, an estimated six to seven doctors (instead of the three-four doctors then at the hospital) were needed in the hospital's Communicable Diseases Clinic (CDC) every day.

This untenable situation forced the suspension of initiating new patients onto antiretroviral treatment by the hospital on 6 May 2009.

In ten weeks, by 14 July 2009, the waiting list had leapt to approximately 2000 people (or more than six times the original waiting list).

Crisis escalates and deaths result

By June/July 2009, Grey's Hospital in nearby Pietermaritzburg was assisting by initiating pregnant women onto ARV treatment but it could not afford to maintain their treatment as their facilities were also overloaded. As a result, pregnant women were referred back to Edendale Hospital to continue treatment at a rate of five per week.

By 14 July 2009 doctors and nurses at Edendale said patients were dying "every week" yet the provincial health department did not seem to be in a hurry to address the critical shortages of staff and space causing the antiretroviral programme's suspension.

*Zakhele Ndlovu**, a 38-year-old security guard from Imbali, said he had gone through his ARV readiness training late in 2008, then waited four months to get on ARVs. As his CD4 count fell to 114, a relative arranged for him to get ARVs from RK Khan Hospital in Durban. He said:

“My friend who was also waiting with me to get ARVs died while waiting, and I realized I could have died like him...”

Thembinkosi Zuma, 27 years old, was diagnosed with tuberculosis and died on 1 June 2009 after waiting to start ARV treatment since his CD4 count was recorded as 47 in March.

By 15 July 2009 an unnamed doctor in a newspaper report said up to a quarter of those on the waiting list could still die as their CD4 counts were so low that it would be difficult to rebuild their immune systems.

Sibusiso Ngubane, 35 years old, who went blind while on TB treatment in 2008 had his CD4 count drop to 13 by January 2009. His mother went on ARV readiness treatment for him and after nearly six months on the waiting list for ARVs he had retreated inside under his blankets saying in July he would not go outside:

“What is the use if I don’t see anything?”

He later died on 13 August 2009, two weeks after starting ARV treatment.

Even for those on the waiting list who were still alive, it was hard to continue to have hope amid such difficult conditions.

Noluthando Zondi*, 23 years old, seven months pregnant, unemployed and HIV positive, when unable to get ARVs although her CD4 count was a dangerously low 48, went to the city’s Grey’s Hospital but was told by a nurse she had to get ARVs at Edendale Hospital:

“I was disappointed that I wasted R32 on transport money to get there for nothing...”

Seasonal plantation worker ***Elizabeth Lesedi****, 35-year-old mother of three, with a CD4 count of 183 in February 2009, who has been on the waiting list since she completed her ARV readiness classes in March, said:

“I regret going to test. It is better to live not knowing you are sick if you are not going to get help. My mother is saying if I did not test I would not be so anxious, I would be feeling better.”

Former gardener ***Abel Madlala**** (47), on the waiting list since February, losing weight, coughing and with continuous diarrhea, said:

"I am glad to hear the news about the coming changes at Edendale and I have not lost hope, even though one gets desperate after waiting for such a long time."

Early in July, SA HIV Clinicians' Society chair, Dr Francois Venter, said in a letter to the provincial MEC for Health on the crisis at Edendale Hospital, that delaying ARV treatment for patients with low CD4 counts and opportunistic infections causes "unnecessary" sickness and deaths:

"Regardless of the challenges that the health care system faces in terms of infrastructure and staffing constraints, it is never acceptable practice to halt the initiation of new patients onto ARV treatment," added SA HIV Clinicians' Society chair Dr Francois Venter.

Further consequences for patients: unemployment and poverty worsens impact of waiting on list for ARVs

The severe health problems and psychological stress of lack of access to ARVs and the stalling of the waiting list process was made worse through the high levels of unemployment of those on the waiting list, and the high levels of poverty in the District.

TAC's Ntombizonke Ndlovu said of blind Sibusiso Ngubane above:

"I was shocked when I visited him at his home. He had nothing to eat, lying on a bed being looked after by his unemployed mother. Then he had no grant. ... After this I talked to Dr Ndlovu, who runs the HIV Directorate in the Premier's office, and she gave me someone to link to for food parcels while she organized someone from the South African Social Security Agency (SASSA) to assist him in applying for a grant. There are lots of others in the same position, according to the CHAs." [CHAs are volunteer community health activists who are members of TAC.]

The situation in Edendale is similar to those reported at HIV treatment sites in Bloemfontein, where a number of social and health factors impact to worsen people's health once they are in need of antiretrovirals:

"People wait till they are desperately ill before they go for VCT. They are very, very sick and weak when they get to the ART sites/clinics/hospitals. They have to wait for hours. They get told to come back for a CD4 count test. They do not have food to eat at home. They do not have taxi fares. They are too weak to walk to the clinics. They do not understand the whole lengthy process. They are too weak and sick to attend drug-readiness classes for three days. They cannot walk the distance daily to the clinic to get Streptomycin injections which many people need for recurring TB and they cannot pay the R50 for a private car to take them there and back for the injection..." says a member of the Free State Health Coalition.

But as opposed to Bloemfontein, in Edendale and the Umgungundhlovu District the distances are even greater, and those on the waiting list were several months weaker.

Hospital staff also on waiting list

With an estimated 2 000 nurses dying a year from HIV, (according to an Edendale Hospital doctor's report to a meeting with the Umgungundhlovu District in 2007), there was an urgent need to initiate the nursing staff who needed it on ARVs. Despite ill nurses continuing to work to provide an income for the family, there was continual need to retrain, to replace staff.

There was an emotional drain on the healthcare staff as those working with HIV-infected patients and their prolonged suffering and high mortality were experiencing severe psychological trauma. The hospital staff also needed a qualified psychologist to debrief health care workers, which was not available.

Community angry at lack of information

Another consequence of the suspension of ARV initiation without any public announcement, was the lack of information to the community from the hospital or the Umgungundhlovu District, which resulted in patients becoming angry over the delays in treatment. This frustration was taken out on any accessible health care workers like the nurses at the clinics or even the hospital staff.

TAC's Ntombizonke Ndlovu said:

"Another impact has been that the patients are starting to make threats to the nurses at the clinics, accusing nurses of selling their medication. Not enough has been done to inform people. I know this through interviews at Mpilonhle clinic where one sister is thinking of resigning; this is also as she works alone, there are very long queues, and sometimes she has no lunch. She just eats when she can or the patients get very angry. When we asked why she was alone, the Department of Health said it was not their clinic but a municipal clinic. At Sobantu clinic the counselor did resign for this reason; there is no counselor there now."

There seems to be poor communication around ARVs in the District.

Local TAC fieldworker and activist Ntombizonke Ndlovu related a series of five meetings with various local health department officials, clinics and community organisations in May-July and said:

"The problem seems to have started long before May 2009. TAC's community health advocates (CHAs) reported there were long waiting lists to go on ARV treatment at Edendale Hospital, for example one person told us they went to the usual series of three classes on adherence to ARV treatment in November 2008, and by April 2009, not one of that class had yet been called to start their ARV treatment. A sister at Esigodeni clinic, one of the 21 clinics who refer patients to Edendale Hospital, told us that none of her patients had been initiated onto ARVs since about October 2008. Five of them had died. All the clinics have problems. At

Mpumuzu clinic, the sister there did not want to talk to us, she referred us to the District.”

Ntombizonke Ndlovu added that in May 2009 the TAC’s co-ordinator for the Umgundhlovu District, Richard Shandu, held a meeting to discuss HIV treatment challenges around Edendale, and the placement of treatment literacy practitioners (TLPs – who offer patients queuing at primary health clinics information about HIV and ARV treatment). She heard that this meeting was attended by Umgungundhlovu District health officials, the provincial HIV, AIDS, STI & TB unit (HAST) manager Roger Phili and TAC’s Promise Makhanya (CHA co-ordinator) and Themba Mapumulo (prevention and treatment literacy co-ordinator).

After TAC was given the go-ahead to place TLP’s in the district clinics, the Umgungundhlovu District officials acknowledged the problem of delays in initiating ARVs. They said they were thinking of task-shifting and using NGOs to free up the Department of Health nurses (e.g. TAC for treatment literacy and other NGOs for HIV counselling and testing). They said this would be in place by October or November 2009.

“At that time TAC did not know that Edendale hospital was about to stop initiating people on ARV treatment completely. TAC only found this out in the middle of June 2009. When I had a meeting with the sisters at Caluza clinic on about 10 June 2009 they told us there was a waiting list of about 180 patients. They mentioned the hold-up was Edendale Hospital, and that most of their patients had low CD4 counts. They said the problem at Edendale Hospital was that there was no space to treat the people waiting, as they were treated at a separate building being the clinic for communicable diseases but this was very small. It has its own pharmacy, also very small. The sister said she did want to help people, but there was nothing she could do.”

SECTION TWO: Provincial authority only responds once situation escalates into fatal emergency

In this section, the report includes an overview of the background to the suspension of ARV initiation, including the barriers to the rollout of antiretrovirals, and the other HIV-linked treatment gaps (for rape survivors and new-born babies).

We cover the sequence of events leading up to the suspension and the response by the Provincial Health Department and how only the complete breakdown of the hospital's ability to take on any additional patients in the ARV unit triggered a response from the Department of Health. The Department then acted decisively to deal with the emergency and public outcry (but this has not yet resolved all of the conditions that prompted the emergency, meaning it may arise again).

We cover the finding of one person to take the blame and her dismissal; then later, once the hue and cry had subsided, her subsequent reinstatement. We cover the ongoing problems still to be addressed at the hospital.

Barriers to antiretroviral rollout

By 2007, a local NGO, iTEACH, based inside Edendale Hospital, had already documented the main barriers to rapid expansion of the ARV programme. These included, amongst others, the centralisation of treatment sites far from patients' homes and the associated transport costs, the shortage of health care workers available to the programme, high rates of TB co-infection amongst the patients, , unemployment, the lack of food security, misinformation about ARVs versus traditional medicines, the failure to integrate traditional healers into the ARV programme, and the lack of community involvement in the programme generally. Currently, iTEACH is running a successful collaboration and training programme with local traditional healers as it estimates that 8 out of 10 sick people in KwaZulu-Natal visit a traditional healer before seeking assistance in the public health system.

Outside of the work of iTEACH, most other barriers remain despite some level of community action and collaboration from doctors in the private sector.

Another related treatment gap: resources for rape survivors and new-borns

A doctor at Edendale Hospital said another gap in treatment resulting from insufficient staffing at the hospital, was the inability to manage the provision of post-exposure prophylaxis (PEP) to children and adult rape survivors as well as an inability to follow-up infants exposed to perinatal infection.

About 213 children and adults had been seen at the hospital's Crisis Centre from January to October 2007. About 38% of these, or 81 of the rape survivors, were started on antiretroviral post-exposure prophylaxis.

Unlike Northdale Hospital, Edendale Hospital did not have 24-hour cover from District Surgeons, so this had meant that many of the rape survivors had not seen a doctor. A 24-hour service would have greatly increased the number of survivors able to access prophylaxis (and the number of HIV infections prevented) and would improve the medico-legal service.

The doctors asked the hospital to consider establishing District Surgeon cover as a matter of urgency, and discussed interim temporary measures.

Three year delay

This issue, along with the growing waiting list and the staff and space issues, despite three years of letters to, and meetings with, the Umgungundhlovu District and Province to approve more staff and expanded buildings, or even to approve interim staff and structures offered by local NGOs, was not addressed during this time. Nothing was done by the Umgungundhlovu District and the Provincial Department of Health to address these problems.

Hospital resources finally break down

On 6 May 2009 the hospital stopped putting new patients on antiretroviral therapy as it did not have staff or space to cope with more patients without compromising the care of the existing patients, some of whom had already been unable to get their monthly medication because of the shortage of pharmacists.

A volunteer based at the hospital said: "As a result on Wednesday 6 May 2009 Edendale Hospital stopped initiating new patients onto ARVs. This was decided by the ARV Manager Dr Hlubi Dlwati, the head of the ARV pharmacy Dr Thanushya Pillay, the ARV co-ordinator Thembi Shange and with Dr Doug Wilson, the Head of the Department of Medicine. There were no drug shortages. This was decided, knowing that lives would be lost. But they hoped such a dramatic step would be calculated to generate enough attention to breach the walls of Natalia (the central PMB offices where the provincial government is located). They then informed the Department of Health and within 60 minutes a person from the Umgungundhlovu District Office was sent to investigate and made some promises. Then it hit the media. The new MEC of the Department of Health then announced that the ARV initiation had not been stopped, which he later retracted, saying that he had been wrongly briefed."

Emergency response

By Monday 13 July 2009 the KwaZulu Natal Province's MEC for Health, Sibongiseni Dhlomo, had been aggressively investigating and taking an active interest. He visited the hospital, and held a public meeting in the hospital on Tuesday evening at which he offered roving microphones to anyone who wanted to speak or ask questions, in front of the press.

Public protests

Public protests escalated to an 80-person morning vigil on 15 July 2009 outside the hospital.

HIV activist Phumlani Kunene told the vigil those who had died waiting for ARVs had not died in vain, as government was by then addressing the problems.

The TAC called a city-wide march on 16 July 2009 to protest against inadequate health services for people living with HIV. Local TAC spokesperson Richard Shandu said there should be an emergency rescue plan in such circumstances. This call had been echoed by supporting NGOs, including the Pietermaritzburg Agency for Christian Social Awareness (PACSA)'s Lindani Hadebe, who said too few doctors and pharmacists held back service delivery. The Green Network's Sandile Sithole, representing 45 community-based organizations in the area linked on socio-economic issues, said the whole government should respond, this was not just the responsibility of the Department of Health. All three said there should be a short time-frame for an urgent response.

At this protest TAC asked for an indication of when this would start, so as to be able to give people hope.

"They feel they are going to die and nothing is being done. We need this now, not in 2010. There are over 2000 people on the waiting list now but half of them will be dead by 2010. The MEC did not commit to any date. Also in that meeting, a counselor from Edendale said they want this plan pushed forward. It is not good for them to train people in adherence and after the classes they stay at home and forget. At the same time as the training they do baseline blood tests which are costly and the results are useless if there is a long delay. It is wasteful to have to do all these things again."

After these demonstrations and six weeks of press reports, the Province held a series of meetings with the hospital to resolve the problems.

Someone found to blame, then later quietly let off the hook

On 15 July 2009 the Provincial Health Department announced it had dismissed the Umgungundhlovu District Manager Mavis Zuma, allegedly for failing to manage the ARV rollout, and failing to allow NGOs to help the department to deal with the numbers of patients wanting to enroll in the programme.

Earlier, the intention of the doctors handling the ARV rollout at Edendale Hospital had been to collaborate with a team led by the local branch of international NGO, BroadReach, funded by the US President's Emergency Plan for AIDS Relief (PEPFAR) programme. BroadReach had been working in conjunction with a consortium highly capable of rolling out HIV/AIDS and related treatment. This included the Harvard Medical School Division of AIDS, Aid for AIDS, and the Willow Creek Association in partnership with the Government of South Africa, strong local partners and faith-based organizations.

This would have been an extension of BroadReach's work, and Edendale Hospital had been working with BroadReach over 18 months on capacity-building including clinical training and support.

The hospital wanted to expand this successful collaboration to cover at least human resource support, technical expertise, staff training, data management monitoring and evaluation support, procurement of equipment and infrastructure, treatment literacy and community mobilization, but required the official permission of the Umgungundhlovu District to do so.

Instead the Umgungundhlovu District Manager Ms Zuma had allegedly told the Provincial Health Department that Edendale had reached its ARV target and was slowing down due to less demand [see It later emerged (on 31 July 2009) that Ms Zuma was merely transferred to her choice of level 13 post in the Health Department in the region, following an application to the Labour Court to challenge her

dismissal as unfair. It is not possible to know from the terms of the Labour Court settlement agreement whether this was a legal compromise due to hasty action by the Department which had not been procedurally fair, or a recognition from the Department (no longer under the spotlight of public attention) that the fault lay with the Province more generally. Subsequently, Ms Zuma was able to return to her same position as District Manager of Umgungundhlovu.

On 16 July 2009 BroadReach, the bigger of the two NGOs who had been offering assistance to the Edendale Hospital over years but stalled by Ms Zuma, again offered support.

Steps to address the emergency, and ARV initiation starts again

On 20 July 2009 the hospital started, with the help of new sessional doctors and pharmacists, to start 10-15 patients a day on ARVs. This was expected to eliminate the waiting list in a month. The sessional staff were to complement the four doctors and two pharmacists already running the ARV programme. Renovations of the new antiretroviral pharmacy were completed with the assistance of BroadReach Healthcare.

An NGO located inside the hospital, iTEACH, was permitted to manage the patient list and do clerical work to prepare patients and shorten doctors' time needed (45 minutes reduced to 5 minutes on average) and to fast-track the initiation of patients (to 14 days).

Ongoing issues

The hospital still faces a staff deficit and space constraints.

It needs, to expand HIV, AIDS, STI & TB UNIT (HAST) service delivery in the 2009/2010 financial year, to replace doctors leaving the ARV rollout with equivalent contract posts until the permanent posts have been unfrozen, to employ two more senior doctors, one more principal or chief pharmacist, to employ a tuberculosis coordinator until this post has been created, to renovate the new offices for the social workers and to construct an enlarged temporary waiting room in the CDC with good ventilation to reduce nosocomial transmission of tuberculosis.

Stable patients who have been on ARVs for at least three months are being transferred to nursing staff at the 17 fixed clinics and six mobile clinics for ease of access and to ease the hospital's congestion, but this means providing more facilities at and to clinics (lockable storage, cars to transport medicines, doctors to handle problems, pharmacy assistants to dispense the drugs).

SECTION THREE: Shortage of staff

In this section the report covers the first main cause of the suspension of ARV initiations in 2009: the ongoing staff shortage.

It also covers measures taken after the emergency to address the staff shortage, and highlights issues which have not yet been resolved.

Reasons for staff shortage and extent of the staff shortage

The first of the two primary causes of the ARV initiation suspension was the staff shortage. Recruiting staff was difficult because of the huge patient loads, long hours, poor facilities and lower payment rates than in neighbouring hospitals (the hourly sessional rate was R20 less than other health facilities).

Delays over these three years in appointing staff due to inefficient human resource processes and political uncertainty in the Umgungundhlovu District and Province, led to doctors and pharmacists leaving, and taking a long time to be replaced or partly replaced, while the workload increased substantially.

The hospital ARV staff tried all available resources, including using the local private general practitioners, where GPs were trained in HIV/AIDS management and treatment, to assist at public sector ART roll-out sites. Other GPs were recruited to treat public patients from their consulting rooms to lessen the burden on clinics and allow patients to be treated closer to where they lived. This was initially funded by local NGO BroadReach and the plan was to transfer these patients back to the hospital once there was sufficient capacity.

The bureaucratic delays were exacerbated by the fact that for nearly 12 months during 2008/9 the hospital had neither a Chief Executive Officer, nor a medical manager.

Underspensing and other budget cuts

The delays were made worse later in this period by a moratorium on employment of new staff and the freezing of posts due to budget cuts following under-spending of grants in 2008.

The Edendale Hospital ARV programme functions on a conditional grant to the provincial health department and in 2008 only 80% of this money was spent, so the budget for 2009 was cut just when the need was escalating dramatically.

In response to years of requests from the Edendale doctors for more information on the plans and intentions of the Provincial Health Department, in early June 2009 the Provincial management said a detailed business plan did exist for the hospital. This plan was said to cover the number of patients per site and the amount of funding available.

The Provincial management also said there were constant calls from all the hospitals in the province to unfreeze posts and that the proposed Edendale Hospital ARV unit organogram was “enormous”, “unaffordable” and “not practical as it was not funded”. However the Provincial management did add that certain posts might be funded out of the Province’s conditional grant (and others from the equitable share).

Medical nurses do not receive the OSD

Another factor is the confusion at Provincial level caused by the implementation of the Occupational Specific Dispensation (OSD) allowances for nurses. This led to a considerable additional and apparently un- or under-budgeted outlay by the Province on salaries, affecting the budget available for additional staff.

Nurses in the wards at Edendale Hospital do not receive the OSD. This is because, being seen as medical nurses on the wards, and not having studied a post-basic qualification in medical nursing, they do not qualify for the OSD. As a result the nurses are choosing to leave the medical wards and care of medical inpatients is severely compromised. Given that adult mortality on the wards has doubled in the context of the HIV/TB epidemic, the need for skilled medical nursing is increasing.

According to one doctor at Edendale Hospital: "In addition to lower pay, the medical nurses have to contend with:

- *a higher nurse-to-patient ratio and a greater workload;*
- *large numbers of seriously ill immobile patients with AIDS, and/or tuberculosis, diabetes, stroke, heart failure, renal failure and liver disease;*
- *the need to monitor and act on blood pressure, temperature, heart rate, oxygen saturations and glucose readings; and administer medications, fluids, oxygen and pressure care to these patients;*
- *emotional exhaustion from large numbers of young HIV-positive patients;*
- *risk of infection from tuberculosis (including multi-drug resistant tuberculosis) and HIV (from needle-stick injury);*
- *risk of physical injury from violent psychiatric patients..."*

Interim solution to extend ARV sites

By the end of July 2009 the proposed additional interim solutions were for

- a sessional doctor to starting initiating ARVs for TB patients at next-door Doris Goodwin hospital, (which began in August 2009) and for
- a travelling team (doctor, pharmacy assistant and social worker) to start patients on ARVs at the 13 feeder clinics staffed by nurses trained in managing people on ARVs.

Since the May-July moratorium, the Department of Health has accredited five clinics, being Caluza, Mpumuza, Songonzima, Taylors' Halt and Gomane, to initiate ARVs using a PEPFAR-funded roving team. However capacity remains limited at these new initiation sites, as most are short of counselors, dedicated ARV clerks, data capturers and nursing staff.

Ongoing issues

Despite the lifting of the moratorium, many of the problems persist. The huge patient load will still lead to a constant turnover of doctors in the hospital's Communicable Diseases Clinic (CDC) and each time a doctor resigns there is a long delay in their replacement.

There is no movement to allow nurses to begin front line management of stable patients, to free up doctors.

There are still long delays of up to a few months before initiating pregnant women with CD4 counts of under 200 on ARVs.

Despite the enormous efforts by the initiation team visiting the feeder clinics, these will not remain stable without each having their own dedicated ARV nurse, clerk and sufficient counselors.

One related problem is that chronic ARV medication to the clinics is pre-packed at the ARV pharmacy for sending to the clinics, but it is hard to estimate the needs of a particular clinic accurately due to the difficulty in getting the chronic medication cards sent back from the clinics in time for the next package. Another related problem is that blood samples are drawn at the local clinics and the results are supposed to be sent back to the clinics using the same transport as the medication. But as the delay in getting the PCR results back is sometimes more than a month, so this is hard to synchronize.

SECTION FOUR : Lack of space and equipment

This section of the report provides more on the second major cause of the suspension of ARV initiations at Edendale Hospital in May-July 2009: the lack of space and facilities. It covers the size of the waiting room and pharmacy, hard-to-access patient information, no space and resources for adequate data management, and the urgent need for additional support and equipment.

Pharmacy hopelessly overcrowded

A breakdown of pharmacy services had been developing for some time. On 28 March 2008 the Pharmacy Manager at Edendale Hospital Dr Thanushya Pillay wrote to the chairperson of the Umgungundhlovu District ARV Committee Dr Muller asking for urgent changes, and for him to visit and see for himself regarding the situation at Edendale Hospital. According to her letter [paraphrased]:

'By March 2008 there were then just over 10400 patients (adults and children) collecting ARVs from the Edendale Hospital pharmacy, both at the hospital itself and the peripheral clinics, with an additional average uptake of 400 new patients per month, meaning about 170 patients per pharmacist per day, which was barely manageable.

The pharmacy where the prescriptions were dispensed was about 17m², and the separate pharmacy where the prescriptions for the clinics get dispensed was about 9m².

There were then three full-time pharmacists, four full-time pharmacy assistants, one or two data capturers, and one pharmacist intern. When assistance was required, an additional pharmacist and an additional assistant/intern was also sent to the ARV pharmacy, meaning a total of 12 people to fit in-between the two large work surfaces, a computer, stools, and shelving all along one wall for the drugs (other drugs were stored in an additional locked store room). This was a severely constrained space.

The pharmacy staff (taking staggered breaks) kept it open from 7h30 to 4pm, and often 5pm.

This meant that to manage more new patients (following the national Criteria for Expedited Antiretroviral Initiation [only introduced in 2009]) there should be the following urgent changes:

- *Bigger premises (with enough space for a patients waiting room and dispensing hatches), with enough space both for 400 new patients a month and more patients in the future*
- *Safe and secure medicine storage*

- *space to do labeling and packing*
- *enough staff to cover the work, meaning three more pharmacists, eight more assistants, two data capturers, a clerk and one stores/general assistant.’ [considerably paraphrased]*

Provincial health department spokesperson Leon Mbangwa said on 15 June 2009 that the pharmacy was being extended and “...we are hoping the construction would be completed by the end of the month”. This has happened.

Registry and consulting space for doctors

Similar space constraints face doctors. Already by April 2008 the Communicable Diseases Clinic (CDC), was only being able to accommodate 30 patients, whereas 180-200 patients were being seen on a daily basis. In the same way, the HAART clinic could only accommodate 10 patients and the rest had to wait outside until they were seen by a clinician. The files also had limited space, and more staff were needed to address the problem, as outpatient files were not issued after 14h00 unless there was an emergency.

We observed that by May 2009 the patients were still being treated in the CDC, an old prefabricated building at the back of the hospital, where at one time 70 people were crammed into a room having their weight taken (it doubled as a drug readiness training room for new patients), while another 60 patients sat in the waiting room. This waiting room was packed, and then patients perched in seats lined up down the corridor, with barely any space for a person to walk down it. Doctors shared examination rooms, sometimes even seeing two people at once in one room (so patients had to move in and out if undressing is involved, but this was hardly private).

Many patients in the waiting room were co-infected with TB (including drug-resistant strains) and other infectious diseases, placing the immune-compromised patients at high risk of transmission in the crowded and poorly ventilated conditions. This space then had to cater for more than 11000 patients on ARVs.

No adequate provisions for efficient and time-saving data management

The data capturing office is too far away from the clinic, in a separate building on the 4th floor, and the four-drawer filing cabinets were all full. New patients’ files were on the floor while they were being initiated daily and there was no down-referring.

The hospital still needs an appropriate data base, which should have been provided by the National Department of Health. This is, as well as clerks to maintain it and computers (as well as space to use them) to record ARV/TB patient registration, pharmacy, patient visits, episodes, follow-up bookings, laboratory results.

Access to important laboratory results by CDC doctors remains a challenge, as an effective online linkage between Edendale’s laboratory and the clinics/wards does not exist. Up until September 2009, viral load testing was performed at Inkosi Albert Luthuli Central Hospital laboratory in Durban and results were uploaded onto the intranet, such that CDC doctors who had intranet access could look up results. Viral load testing is now done at Edendale Hospital, which has caused an increased challenge as there are not enough staff in Edendale’s laboratory, which results in delays in obtaining these paper-based results.

Infrastructure upgrading still lagging

By 4 June 2009 the Province said there should be interim plans as Edendale Hospital was scheduled to be split into two in the upcoming “revitalization”.

The hospital has finished rebuilding the pharmacy area.

In the longer term the hospital hoped to be able to extend the CDC which was very small and crowded, and build a new clinic at the hospital entrance for adults needing ARVs.

In the interim it was proposed that a canvas marquee for the waiting room, and an air-conditioned steel container for the records and one social worker, should be procured.

By January 2010 the promised filing room container and waiting room tent had not yet come, but plans for a prefabricated extension to the waiting room had been finalized.

SECTION FIVE: Province's lack of strategic planning and poor communication unconstitutional

This section of the report highlights the consistent effort, from May 2006, of ARV rollout staff at the Hospital to pre-empt the emergency suspension of ARV initiation. It deals with budget cuts, stock outages, the human resource crisis at Umgungundlovu District and Provincial level, the poor communication from the Umgungundlovu District and the Province.

This section also notes that the doctors at the Hospital have not yet received a response to their petition, sent after the suspension of ARV initiations had been in effect for five weeks, stating that the Department of Health had a constitutional duty to develop a rational plan to progressively realize access to health care services and they wanted to assist management in achieving this.

Attempts by health care workers to prevent a crisis

Three years before the current crisis in May 2009 (in May 2006), doctors at the hospital started trying to pre-empt it.

Over a three-year period over 30 letters were written [see Appendix 2] motivating for new staff and providing detailed organograms for the ARV establishment at the hospital (on 16 May, 23 and 26 October 2006; 18 and 22 January, 14 February, 18, 20 and 23 March, 13 April, 14, 21, 23 and 28 May, 5 and 21 June, 13 and 17 July, 31 August, 8 and 22 October 2007; 4 February, 3 and 28 March, 3 and 21 April, 13 August, 30 October, 9, 11, 12 and 18 December 2008; 23 April 2009). These letters were addressed to the hospital manager, district/provincial officials and NGOs.

Yet in all this time there were only two written responses (one on 26 October 2006 and one on 19 February 2007) from the Hospital's own Manager and one telephone call from the Umgungundlovu District recorded in reply. The Manager said the creation of posts was "not a quick process" and five months later was the earliest possibility; in the second reply she gave permission, in principle, to transfer the patients initiated on ARVs by General Practitioners back to the hospital when there was capacity.

During all this time the Edendale doctors also set up a series of about 12 meetings (on 16 May 2006; 19 January, 14 February, 21, 23 and 28 May, 5 June, 8 October 2007; 4 February, August, 18 December 2008; 23 February 2009; with NGOs, the Umgungundlovu District Manager, staff, IT specialists, Provincial HIV, AIDS, STI & TB UNIT (HAST) officials, the KZN Pharmacy and Therapeutics Committee) to address these issues, including the collection of data to facilitate the ARV rollout and motivate for these requests.

Shortages of stock reported

On 22 June 2009 KwaZulu-Natal health department MEC **Sibongiseni Dhlomo** said

"...all our facilities have adequate stocks of medication, nutritional support packs and we have not had an instance of running out of stock there can be shortages at clinics because we don't keep them there."

On the same day TAC spokesperson **Richard Shandu** said

“Our field workers have indicated there are huge problems with the supply, distribution and availability of the medication.”

By June 2009 the pharmacy reported stock outages as one of the large pharmaceutical companies had not been paid.

Decade of neglect leads to human resource management crisis

An expert health journalist, commenting on the developments at the time of the crisis at Edendale, has suggested that the Health Department’s human resource crisis had come to a head after “almost a decade of neglect” by former Health Minister Manto Tshabalala Msimang. Despite the good intentions of the OSD, to attract professionals and specialists, the chaos of its implementation, first for nurses then with doctors had led to confusion and mismanagement, delays and frustration, she said.

She suggested that the new minister Dr Aaron Motsoaledi was trying to address inequities in and between provinces, focusing on junior staff first, and identifying problems including “lack of managerial skills in health institutions, failure to respond to identified deficiencies, delayed response to quality improvement requirements... inability of individuals to take responsibility for their actions, ... inadequate staffing levels in all areas”.

Petition by doctors

In 15 June 2009 [see *Appendix 3*] many of the doctors at the hospital had signed a petition saying that they were committed, as employees of the KZN Dept of Health, to progressively realizing their patients’ healthcare rights and that they had identified realistic management outputs required.

The petition explained that from December 2008 they had been using the official channels with no response and they had found themselves in a crisis. They wanted to be told who was responsible for what in the Department so that they could get hold of what they needed. This also included a detailed list of all the required improvements with timeframes, including addressing the staff and space shortages including the appointment of a Hospital Manager and Medical Manager, and the Provincial Health Department providing regular information on strategic plans.

By September 2009 some new doctors had been hired, the pharmacy had been expanded, and NGOs were providing financial support for staff and equipment; but some of the other proposals have not yet been addressed. The appointment of a new Hospital Manager or CEO Ms ZSI Ndwandwe, and a new Medical Manager Dr S Bhimsan, should assist in streamlining this process.

CONCLUSIONS

The example of Edendale Hospital exposes several managerial flaws and a lack of strong oversight institutions, each of which could have been utilised to investigate and prevent unnecessary deaths and trauma for which all levels of the Department of Health bear responsibility. At a managerial level:

- **Accountability of departmental officials and managers** remains a problem. The example of Ms Zuma is one, but the department must ensure that its disciplinary procedures are followed correctly and that they are not only used to quiet public outcry.
- **Callousness towards the lives of citizens:** The fact that the department allowed Edendale to continue in such dire straits for three years, with no interventions by the provincial department of health until the crisis became public reveals a callousness towards the lives of citizens whose access to health care services was restricted by the failing conditions of the hospital. The provincial department of health must be reminded that the right of access to health care services is guaranteed by section 27 of the Constitution and is at the heart of its work. The obligation to respect, protect, promote and fulfill this constitutional obligation must form the basis on which the department reviews its own behaviours and procedures.
- **Lines of Communication:** The National Department of Health should develop and maintain an early warning system to pre-empt emergencies and respond to emergencies as they arise. This early warning system must enable health care workers in the public sector to report complaints regarding district and provincial management and to enable the NDoH to intervene where the provincial and district departments are failing.
- **Fear of HCWs in speaking out publicly:** The Minister of Health should go on record stating clearly that – while health care workers should not resort directly to the media without exhausting internal department of health procedures – no health care worker will be disciplined or threatened with disciplinary action for providing factual information within their knowledge to investigators (including the media) on the problems faced at their facilities and throughout the health care system. This includes those health care workers who actively involve the media after internal complaints procedures have failed to remedy the problem.
- **Disparity between districts:** The national Department of Health, with Provincial Health Departments, should plan how to address the inequalities between Health Districts, and to allocate more resources according to differences in the Districts (e.g. including the need for treatment in each District, and the distances between health facilities in the District).

While the above form a principled position the departments should take up, they are also part of a larger legal framework that should be in place, but has been largely left unimplemented by both the national and provincial departments of health.

- **District Health and Human Resource Plans:** Section 33 of the NHA requires each district health manager to develop and present to the district health council an annual district health plan. These district health plans should be in the public domain and developed in consultation with representatives from the community being served. Section 33 also requires the development and implementation of district human resources plans. These should be developed alongside district health plans and available to the public. We call for the National Department of Health to annually publish each district health plan and district human resources plan on the DoH website.
- **Hospital Board:** Section 41 of The NHA along with section 36 of the KwaZulu-Natal Health Act (KZNHA) require the establishment of hospital boards and prescribes their powers and responsibilities. Unfortunately, neither section 41 of the NHA nor the entirety of the KZNHA have been brought into force. Amongst other things, Hospital Boards are tasked with overseeing the administration of human and financial resources for the hospital and reporting maladministration of the hospital to the MEC for Health. These sections of both the NHA and the KZNHA should be proclaimed immediately and fully implemented.
- **Monitoring and Evaluation:** Monitoring and evaluation of health facilities is lacking everywhere and is apparent in events at Edendale Hospital. Again, the legislative framework is in place, but has not been implemented by the NDoH or the provincial department of health:
 - **Office of Standards Compliance:** Section 78 of the NHA requires the Director-General to establish an Office of Standards Compliance within the NDoH to ensure compliance with minimum norms and standards at all health facilities. This is a critical office for the NDoH to have in place and could have discovered and intervened in the problems at Edendale before they became critical. While this office has been filled now and has been provided with a budget of R51 million for the 2010/2011 financial year, Section 78 of the NHA remains unproclaimed and therefore is not law. At the moment, any action taken by the Office of Standards Compliance would not be legally actionable until the section is proclaimed.
 - **Inspectorate of Health Establishments:** Section 77 of the NHA requires all MECs for Health to establish an Inspectorate of Health Establishments for their province. Section 63 of the KZNHA details the powers and functions of the inspectorate for KZN. Unfortunately, these sections also remain unproclaimed both by the President and by the KZN MEC for Health. This office is required to monitor and regularly report to the Head of Department any violation of prescribed health care standards, but until the relevant sections of the NHA and KZNHA have been proclaimed, the inspectorate is legally unable to act.
 - **Accurate Information:** Even where information is being reported throughout the national health system, the accuracy of this information is highly questionable. This leads to incorrect targeting and budgeting of programmes such as the ARV treatment programme. The Monitoring and Evaluation programmes, particularly for the

Conditional Grant for HIV and AIDS must be stringent and sufficiently resourced to enable accurate reporting of information.

APPENDIX ONE: “Time–line to Disaster” - Chronology of Edendale moratorium

2004	Edendale Hospital starts to provide antiretroviral treatment (ARVs)
2005/6	The antenatal HIV infection rate recorded in Edendale Hospital’s antenatal clinics from pregnant women undergoing VCT was about 60%
16 May 2006	Meeting of Edendale Hospital doctors with HIV charity NGOs, BroadReach and Elizabeth Glaser Paediatric AIDS Foundation (EGPAF)
2007	The antenatal HIV infection rate recorded in Edendale Hospital’s antenatal clinics from pregnant women undergoing VCT was about 60%
19 Jan 2007	Umgungundhlovu District Manager meets BroadReach
14 Feb 2007	Edendale Hospital doctors meet Umgungundhlovu District Manager and BroadReach
21 May 2007	Edendale Hospital doctors meet BroadReach
23 May 2007	Edendale Hospital doctors meet BroadReach on database and statistics
28 May 2007	Meeting of Edendale Hospital doctors on ARV challenges
5 June 2007	Meeting of Edendale Hospital doctors on strategic plan for data management
8 Oct 2007	Meeting of Edendale Hospital doctors on ARV posts, funding and business plan
2008	The antenatal HIV infection rate recorded in Edendale Hospital’s antenatal clinics from pregnant women undergoing VCT was about 60%

4 Feb 2008	ARV concerns raised at meeting of KZN Pharmacy & Therapeutics Committee
March 2008	Over 10400 patients, adults and children, collect ARVs from the Edendale Hospital pharmacy, with an average of 400 new patients a month or about 170 patients per pharmacist per day
2008	Edendale Hospital loses CEO and medical manager
August 2008	Edendale Hospital doctors meet BroadReach on data management
18 Dec 2008	Edendale Hospital doctors meet Umgungundhlovu District Manager on lack of space and staff
2009	The antenatal HIV infection rate recorded in Edendale Hospital's antenatal clinics from pregnant women undergoing VCT dropped to less than 50% in 2009
Most of 2009	Edendale Hospital still had no CEO or medical manager
23 Feb 2009	Meeting of Edendale Hospital doctors on lack of space and staff
May 2009	About 11 000 patients on ARVs at Edendale Hospital are still being treated in one old prefabricated building at the back of the Edendale Hospital
6 May 2009	Edendale Hospital unable to initiate new patients on ARVs
May 2009	Treatment Action Campaign Umgungundhlovu district co-ordinator meets District Health officials
June 2009	Only four doctors, three pharmacists, an intern and 2/3 pharmacy assistants attend to about 550 HIV positive patients a day at Edendale Hospital
4 June	The KZN Dept of Health says Edendale Hospital is to be split in two in the upcoming

2009	“revitalization”
15 June 2009	About 650 people including 30 children on waiting list for ARVs
15 June 2009	Dept of Health says it plans to extend pharmacy at Edendale Hospital
15 June 2009	Doctors at Edendale Hospital sign a petition`
22 June 2009	KZN MEC for Health says no shortages of medication or nutritional support packs
June 2009	Edendale Hospital pharmacy reports shortage of stocks due to unpaid pharmaceutical companies
13 July 2009	MEC for KZN Dept Health visits Edendale Hospital
15 July 2009	Vigil by staff and family outside Edendale Hospital
15 July 2009	KZN Dept of Health dismisses Umgungundhlovu District Manager Mavis Zuma
Mid-July 2009	Two additional doctors not yet started at Edendale Hospital (although appointed in May)
16 July 2009	TAC and NGOs march through Pietermaritzburg to KZN Parliament
16 July 2009	NGO BroadReach offers support to Edendale Hospital
20 July	Edendale Hospital prepares to start initiating new patients on ARVs, 10-15 patients a day

2009	
21 July 2009	Three sessional doctors and two sessional pharmacists brought to help initiate the patients on the ARV waiting list at Edendale Hospital
August 2009	No container for interim filing room yet; no tent for interim waiting room yet

APPENDIX TWO: Letters written to address ARV provision at Edendale

Date	From	To
23 October 2006	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Mr Roger Phili, deputy manager HAST unit, KZN Dept of Health
23 October 2006	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital Mr Roger Phili, deputy manager HAST unit, KZN Dept of Health
26 October 2006	Ms Heather Findlay, hospital manager	Dr Douglas Wilson, Head of Medicine, Edendale Hospital
26 October 2006	Dr Douglas Wilson, Head of Medicine	Mr Roger Phili, deputy manager HAST unit, KZN Dept of Health Ms Heather Findlay, manager, Edendale Hospital
18 January 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms May Zuma, Umgungundhlovu District Manager
22 January 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital, Ms May Zuma, Umgungundhlovu District Manager
	Ms Heather Findlay, manager, Edendale Hospital	Dr Douglas Wilson, Head of Medicine, Edendale Hospital
14 February 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital
19 February 2007	Ms Heather Findlay, manager,	Dr Douglas Wilson, Head of Medicine

	Edendale Hospital	
18 March 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Dr Ernest Darkoh, CEO BroadReach
20 March 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital Sr Thembi Shange, ARV Co-ordinator	Dr Ernest Darkoh, CEO BroadReach
23 March 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Dr John Sargeant, president of BroadReach
14 May 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital
28 May 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital Dr Hlubi Dlwati, ARV head Dr VK Maistry, Medical Manager	Ms May Zuma, Umgungundhlovu District Manager
21 June 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital
13 July 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital Dr Hlubi Dlwati, ARV head Dr VK Maistry, Medical Manager	Ms Heather Findlay, manager, Edendale Hospital
17 July 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital Dr K Dong, iTEACH Edendale hospital NGO
31 August 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital Dr VK Maistry, Medical Manager

31 August 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital Dr VK Maistry, Medical Manager
31 August 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital
22 October 2007	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms Heather Findlay, manager, Edendale Hospital
3 March 2008	Ms Mariam Cassimjee	Dr Nomonde Xundu, national HAST manager
28 March 2008	Dr Thanushya Pilaye	Dr Muller, chairperson of the District ARV Committee
3 April 2008	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Matron Chinniah, nursing manager Addington Hospital
13 August 2008	Dr Douglas Wilson, Head of Medicine, Edendale Hospital Dr Hlubi Dlwati, ARV head	The Director of the Elizabeth Glazer Pediatric Foundation, SA
30 October 2008	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Mr Study Maramba, BroadReach
9 December 2008	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms May Zuma, Umgungundhlovu District Manager
11 December 2008	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms H Baird, Acting Hospital Manager, Edendale Hospital
23 April 2009	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms H Baird, Acting Hospital Manager, Edendale Hospital
17 June 2009	Dr Douglas Wilson, Head of Medicine, Edendale Hospital	Ms H Baird, Acting Hospital Manager, Edendale Hospital

APPENDIX THREE:

Department of Internal Medicine Edendale Hospital

Postal Address: Private Bag X 509
Plessislaer
3216
South Africa

Tel No: +27 (0) 33 395-4146
Fax No: +27 (0) 33 395-4060
E-mail (DOH): doug.wilson2@kznhealth.gov.za
E-mail (UKZN): wilsond1@ukzn.ac.za



Date: 15 June 2009

Reference: dr.sewlal_request.for.follow-up.meeting

Mrs Holly Baird
Acting Hospital Manager
Edendale Hospital

Dear Mrs Baird

Antiretroviral rollout - request for follow-up meeting

This letter is to request a meeting with Dr Andy Sewlal to follow-up on issues raised at the 04 June 2009 meeting that addressed the stalled antiretroviral rollout at Edendale Hospital.

We appreciate the progress that has been made to date:

- Approval of one Principal Pharmacist post *
- Approval of four Pharmacy Assistant posts
- Approval for locum pharmacists: one locum pharmacist starting next week and two locum pharmacists starting in the beginning of July
- Some antenatal patients and patients with low CD4 counts will initiate antiretroviral therapy next week
- Permission to advertise one PMO post and one SMO post to fill vacant posts

This will allow us to sustain the patients we currently have on therapy but not to meaningfully increase access to antiretroviral therapy. As employees of the KwaZulu-Natal Department of Health we are committed to the progressive realization of our patients' healthcare rights.

We have identified realistic key management outputs that need to be achieved in order to continue roll out of antiretroviral therapy. From December 2008 these issues have been submitted through the usual channels for the Department, including the District antiretroviral committee. There has been no response. We therefore find ourselves in a crisis situation. The context is summarized in Annexure 1 and the outputs needed in Annexure 2. The purpose of the follow-up meeting would be to identify stakeholders in the Department who can achieve the outputs needed in order to resume the rollout.

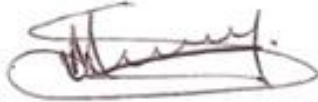
Thank you for considering this request; our signatures are attached in alphabetical order.

Yours sincerely,

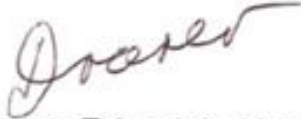
** and two Chief Pharmacist posts*



Dr M Diwati
Head, Adult Antiretroviral Rollout, Edendale Hospital



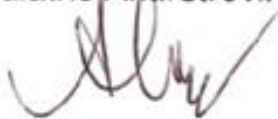
Dr R Draper
Head, Medical Outpatients, Edendale Hospital



PP 

Dr L Hall
Head, Paediatrics, Edendale Hospital

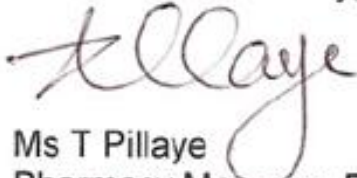
Dr M Krishna 
Head, Paediatric Antiretroviral Rollout, Edendale Hospital



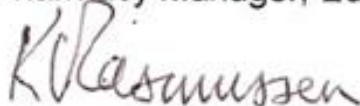
Dr A Michowicz
Deputy Head, Internal Medicine, Edendale Hospital
Chairman, Pharmaceutical and Therapeutics Committee, DC 22



Ms P Pillay
Head ARV Pharmacy, Edendale Hospital



Ms T Pillaye
Pharmacy Manager, Edendale Hospital



Dr Keith Rasmussen
Senior Specialist, Internal Medicine, Edendale Hospital



Sr T Shange
HAST Coordinator, Edendale Hospital

Annexure 1: Context of the Edendale Hospital ARV Crisis

- The Edendale Hospital antiretroviral rollout is the largest in the Province, but has reached only 10-20% of those who need treatment
- The rollout stopped on 06 May 2009 due to limited space, and insufficient numbers of pharmacists and doctors. Children, adults, pregnant women, staff members, and patients with tuberculosis (including multidrug resistant tuberculosis patients at Doris Goodwin Hospital) are equally affected
- Edendale Hospital has not had a Hospital Manager or Medical Manager for almost a year
- Work on the Pharmacy extension stalled on Monday 08 June 2009
- Working conditions in the Pharmacy and Antiretroviral Clinics are unsafe, excessively crowded, and a serious risk for nosocomial tuberculosis transmission
- An oganogram for personnel working on the rollout has been repeatedly submitted but never approved
- The Provincial strategic plan has not been widely distributed

Annexure 2: Management outputs needed to resume the Edendale Rollout

Output	Suggested timeline	Name of person responsible
EDH pharmacists offered additional overtime	20 June 2009	
Social workers relocated from Doctors' rooms in CDC	26 June 2009	
Pharmacy extension operational	30 June 2009	
Organogram authorized [including HAST Coordinator]	30 June 2009	
Briefing on the Provincial ARV Strategic Plan	30 June 2009	
Waiting room tent operational	31 July 2009	
Principal Pharmacist appointed *	31 July 2009	
Organogram funded and advertised	31 August 2009	
Modified container filing room with air conditioning	31 August 2009	
Hospital Manager and Medical Manager appointed	31 August 2009	

* and two Chief Pharmacist posts