



A Dialogue on ART Delivery

A dialogue on the delivery of antiretroviral treatment in resource-limited settings, held at Maropeng, Cradle of Humankind, Gauteng, South Africa, September 2006



Foreword

by Nelson Mandela

IN 2003, I launched the *Siyaphila La* HIV and AIDS treatment programme in Lusikisiki, in the Eastern Cape, a joint project between Médecins Sans Frontières (MSF) and my Foundation.

The project has been a shining example of how an antiretroviral (ARV) treatment programme can be implemented successfully, even in a rural area with few resources.

Today, the project is a useful touchstone in talking about how to achieve the universal delivery of ARV drugs. If we can learn from the lessons of Lusikisiki and other similar projects, it can help us in our long-term fight against HIV and AIDS. Through the communication and sharing that dialogue allows, we will be able to save more lives.

We are now at a point where the project has been handed over to the provincial Department of Health, to continue to run as a successful model for ARV rollout.

We salute the community of Lusikisiki for its active support and participation in this campaign against HIV and AIDS, as well the valuable contribution of the health professionals and government officials who have participated in this initiative.

The success of the *Siyaphila La* project shows that we are breaking down the stigma surrounding the disease, and creating a supportive environment in which HIV-positive patients can speak openly about their status.

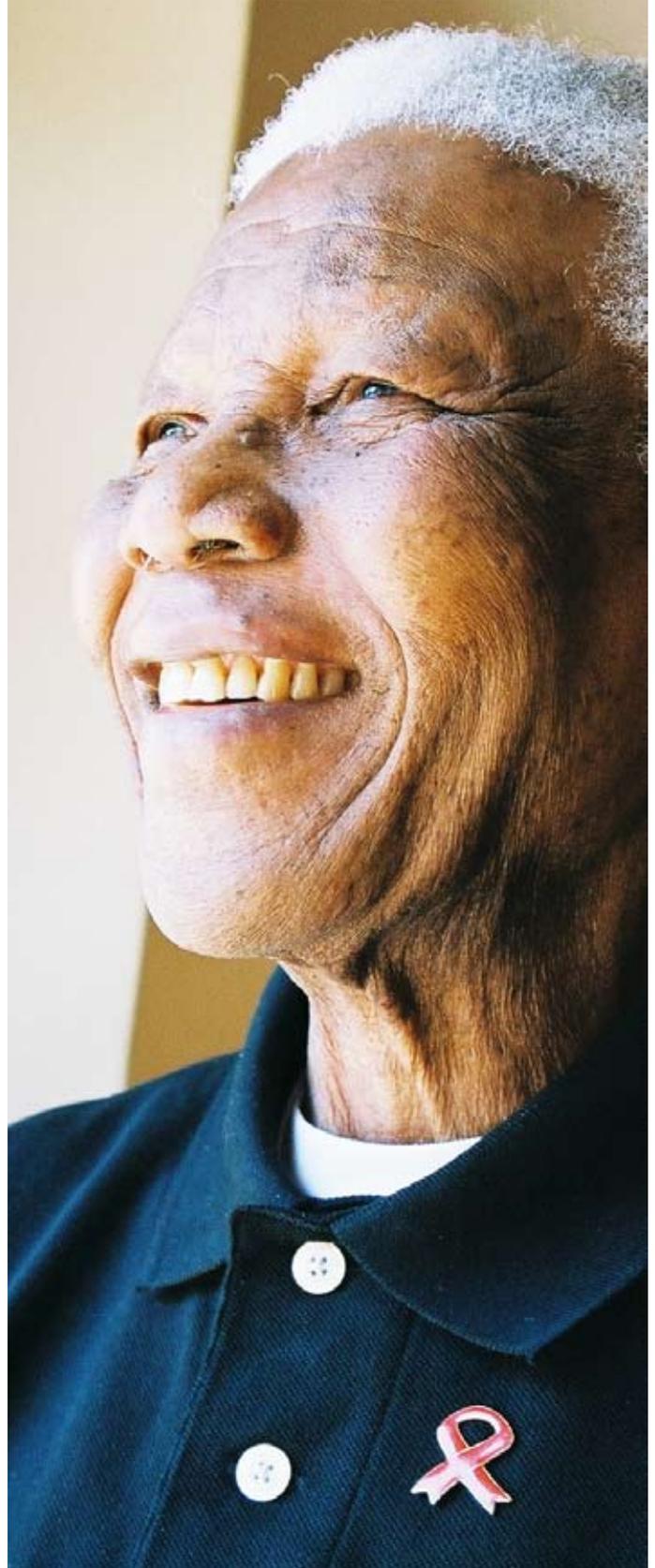
This project shows that the fight against HIV and AIDS can only be won if it is led by the communities affected by the disease, and if government and civil society unite with one another in partnership against the pandemic.

Treatment plans cannot be separated from prevention, care, and support efforts. Through community mobilisation, the availability of ARV treatment can promote greater awareness about the disease, encourage voluntary counselling and testing for HIV among all sexually active people, and enhance home-based care and support.

The name *Siyaphila La* is an appropriate one. It means "We Are Alive". Let us continue to work together, to send that message to communities across South Africa and around the world.

I thank you.

N R Mandela



Photograph: Matthew Willman

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Introduction



THE NELSON MANDELA FOUNDATION convened a dialogue on September 26 and 27 2006, at Maropeng, Cradle of Humankind, in Gauteng. This brought key stakeholders together to share lessons on models of delivery of antiretroviral treatment (ART) in resource-limited settings in South Africa. Delivery of antiretrovirals is a complex issue which demands a multistakeholder approach.

Often we bring people together to listen to experts, ask a few questions and make some comments. The general feeling then is that we have involved them and we call it a dialogue. But we believe that a shift needs to occur which requires the involvement of stakeholders from all parts of the system: business, government and civil society, because complex challenges such as these require a diversity of views.



This dialogue process also marked the end of a successful four-year project run in partnership with the Eastern Cape Department of Health, Médecins Sans Frontières (MSF) and the Nelson Mandela Foundation (NMF), providing antiretroviral therapy to people in Lusikisiki in the Eastern Cape. MSF and NMF handed over the project in its entirety to the Eastern Cape Department of Health on October 12 2006.

The provision of ART is possible in resource-limited settings, as has been proven over and over again; this is no longer up for debate. There is also demonstrable will all around to achieve this, and this needs to be celebrated.



Critical issues such as task shifting, accreditation, nurses prescribing ARVs, human resources, and community involvement, among others, were raised and debated during this dialogue. Concrete suggestions were tabled on what really works.

The dialogue process provided an opportunity for clarifying policy issues. It is our wish that the resulting dialogue outputs are taken up and addressed at the relevant levels through further dialogue and/or other relevant means.

There is a clear need for dialogue, but most importantly, the need exists for an organisation that can convene this dialogue – something the NMF is uniquely placed to offer.



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Fighting HIV and AIDS Head On

Dr Nthato Motlana

GOOD MORNING everybody. I've been associated with the Nelson Mandela Foundation from its very inception.

I was privileged to be Mandela's personal physician, privileged to travel the world with him, and was part of a stage in our nation when there was so much controversy about how we handled this AIDS epidemic.



I recall one president, Ugandan President Yoweri Museveni, coming to South Africa at State House in Pretoria and the kind of discussions some of us had with him. I visited Uganda several times to talk about what they were doing and I regret, as you all know, that our government didn't quite understand what AIDS was all about.

Mr Mandela himself, God bless his soul, he's not a physician, he was a lawyer. He didn't quite understand and I would sit with him and say, "Madiba, what do we do about this damn epidemic?" And it was quite clear that he didn't quite get it.

I mean, he was not opposed as some people became opposed to the campaign against AIDS, but even our wonderful Madiba, I repeat, he didn't quite get it.

But when he realised the need

to do something or say something, that's when I have to repeat, you all know that Madiba really took the bull, as we say, by the horns, and he ran a campaign that really addressed the question of HIV and AIDS.

When the Mandela Foundation was formed, we focused on three areas. We said Mandela is a peacemaker, so the one area would be peacemaking: reconciliation throughout the world. Secondly, Mandela was very keen on seeing that something is done about our schools, so we had a schools or education programme. And thirdly, HIV and AIDS.

Our programme was really a little uninformed. My one attitude, as a former GP in Soweto, was to say to the Foundation, "It's not for us to engage in actual programmes; let us be the kind of think tank that would raise funds all over the world." I mean,

Mandela was one of the best fundraisers in the world, and we would go to Pakistan and Madiba would say to the president of Pakistan: "You, Mr President of Pakistan, your GDP is so and so and so and so. From you we need 10-million American dollars. And then the president would be taken aback and go "um-oh-um-oh". But Madiba would say: "Just call your finance minister to sign the cheque."

And so we could raise funds, and we raised funds. At that time it was for the ANC, of course, but later, after that, we could raise funds for the Foundation. But, you know, the actual programming on the ground was not as it should have been and I thought we should not be involved in the actual projects on the ground. The Foundation is too small to actually be engaged; but, I repeat, when Mandela realised the need to take on the struggle against HIV and AIDS, the Foundation wanted to be there, to be counted as an organisation that would address this problem head on.

And when we went to Lusikisiki, I was there when Mr Mandela, together with Médecins Sans Frontières, called in the first patient, who needed antiretrovirals. ... Oh what a wonderful day!

I'm sorry that I have to go back to Lusikisiki this time, to wind down a programme that I think has done very well.

ABOUT THE SPEAKER

Dr Nthato Motlana was born in the village of Marapyane near Tshwane, in 1925, but moved to Johannesburg at the age of 10, and lived in Sophiatown. Motlana has a long history with the African National Congress (ANC). As a student at Fort Hare University in the 1940s, he became the secretary of the ANC Youth League. He later studied medicine at the University of the Witwatersrand.

Motlana established South Africa's first privately owned black hospital, Lesedi Clinic in Soweto, and the first black-owned company to be listed on the Johannesburg Stock Exchange, New African Investment Limited. Formerly Mandela's physician, he is now the deputy chairperson of the Nelson Mandela Foundation and a trustee.

A DIALOGUE ON ART MODELS: THE PARTICIPANTS



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A DIALOGUE ON ART MODELS: THE PARTICIPANTS



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On the Frontier in Lusikisiki



Lusikisiki

- **Population:** 150 000
- **Hospitals:** 1
- **Rural Clinics:** 12
- **HIV prevalence:** 30% at antenatal clinics
- **Situated:** in the Eastern Cape Province, South Africa. The area contains two of the country's poorest municipalities, Mbizana and Qaukeni

Médecins Sans Frontières Lusikisiki Project Coordinator Dr Hermann Reuter presents a model for universal ARV access in a deep rural area

I'M GOING to present to you the Lusikisiki primary health-care ARV model, which we believe is able to produce universal access to ARVs in a rural site like Lusikisiki. MSF first came to the Western Cape and started ARVs in a township scenario and it was said, "But you know it's easier in an urban area, can you do this in a deep rural area?"

We went to visit Tembi Ntlangulela, local service area manager in Qaukeni, and the first thing she says is: "This is deep, deep rural."

Two of the 10 poorest municipalities in South Africa are Mbizana and Qaukeni, which is our area. In that area we've got a 280-bed hospital and HIV prevalence of about 30% at the antenatal care clinics. Immediately, I

said, for the primary health-care programme, we need to decentralise.

In the middle of the district there's a hospital and then around it are the roads going to the rural clinics: there are 12 of them.

The challenges that we faced, apart from the geographical distances, were that the laboratory services didn't extend to the clinics. There was

poor drug supply to the clinics, there were no HIV services at the clinics at all, there was a shortage of staff and the clinics had not seen a doctor for more than five years.

In Qaukeni, as a whole, there are five doctors per 100000 population, which is 1/14th of the South African average. This is fewer doctors than the Zimbabwean average, than the Democratic Republic of Congo average and the Sierra Leone average. But we are expected to implement the same ARV model as Pretoria.

Testing

Firstly, to get people on to ARVs, they need to be tested. We started initiating Voluntary Counselling and Testing (VCT) at clinic level.

I'm hoping to give an honest reflection of how I perceive the VCT services in Lusikisiki.

In 2003, we did about 900 tests per month (see Figure 1). During that time it was MSF that taught the nurses to do the testing and the nurses were doing the testing. In the second year, we asked the counsellors to do testing as well and the testing increased to about 1200 per month.

At a TB conference in May 2005, when we were told that counsellors were not allowed to do the pricking, but that it should be done by the nurses, this is where we see a dip. We were concerned that if the nurses got the pricking added to their work load that it would impact negatively.

At the clinics, where there were enough nurses, the nurses were actually doing the pricking. At the outside clinics, the nurses are also supposed to do the testing, but if the counsellors see that patients need to be tested, and the nurse doesn't have time, sometimes the counsellor will also do the pricking and that is represented where we did about 1300 tests per month.

Then, suddenly, in 2006, we saw a severe drop in VCT of about 900 tests per month. I'm taking a lot of time for this because often people say an activist organisation or a community-based organisation should ask people to come for testing. And I want to show that the testing rate doesn't depend on the community's willingness to test, but on the services that we are

able to provide, because we see a very low rate there. It is because the community health workers were asked to work for four hours, because they had asked for an increase in their stipends. It wasn't coming, so they were told, "Work four hours". In August, they were asked to work for eight hours again and we tested 1700 people in August this year.

PMTCT

When the prevention of mother-to-child transmission (PMTCT) programme in Lusikisiki was implemented in 2003, the women were asked to go for VCT after their antenatal care visits. So usually the nurses saw the women in the morning and then said in the afternoon, if you want to test, you can. We tested

VCT STATS

VCT Health-Seeking Behaviour

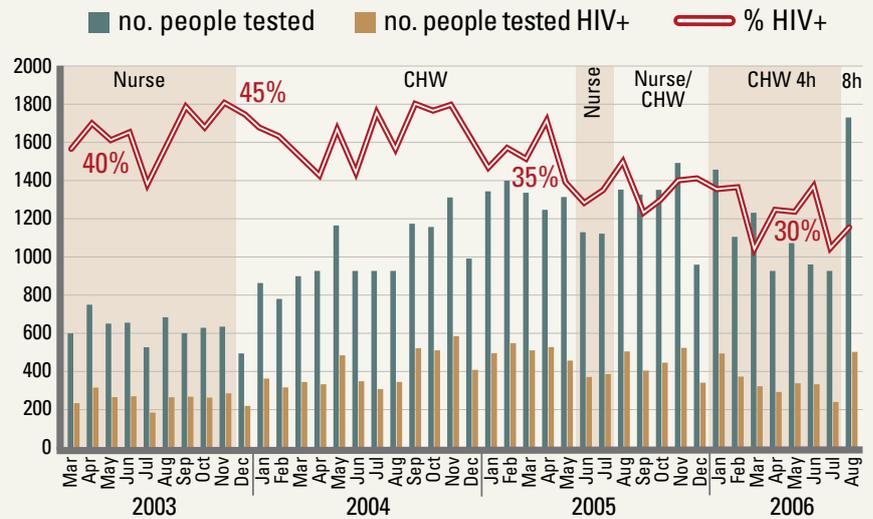


Figure 1. VCT, Lusikisiki, March 2003 – August 2006, 12 clinics.

The number of people tested fluctuates depending on the health services provided. Meanwhile, an expected percentage decrease in people testing HIV-positive occurs as more people use VCT services.

Optional vs Opt-Out

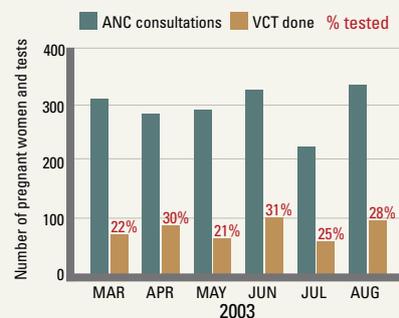


Figure 2. VCT done at ANC consultation, March – August 2003.

In 2003, women were asked to go for VCT after an antenatal care visit. Average testing rate: 24%.

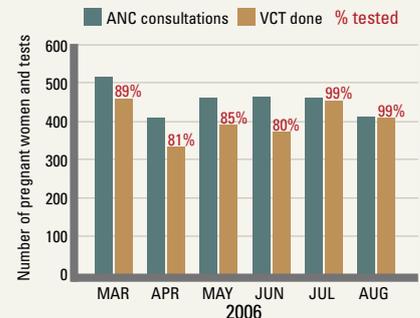


Figure 3. VCT done at ANC consultation, March – August 2006.

In 2006, women first have an opt-out VCT session before they see a nurse. Average testing rate: 89%.

an average 24% of women, and then the baby had to be tested at 12 months, and we didn't know, we couldn't give any outcomes reports at all (see Figure 2).

In 2006, we've now got an opt-out strategy where the woman starts with VCT before she gets seen by the nurse. When she gets seen by the nurse, the nurse already knows her HIV status, can do a CD4 count and can get her onto ARVs if she needs them. By changing the management of the clinic we've now got a testing rate of 89% throughout the 12 clinics of Lusikisiki (see Figure 3).

We've also introduced dry blood spot blood testing and doing Polymerase Chain Reaction tests (PCRs) at six weeks on the babies and, looking at the two busiest clinics, I've

just counted the last 100 results, consecutive results that came back – there was a transmission rate of 12% at each one of those two busiest clinics, which is more or less what one expects with the Nevirapine-only intervention. If we had an AZT-based intervention it could probably come below 6-7%.

Integrating HIV and TB Care

We are happy to be able to give ARVs at the clinic level because TB is a clinic-based programme. TB and HIV need to be integrated and so giving ARVs at clinic level is an ideal opportunity to integrate TB and HIV programmes. At the clinics outside Lusikisiki, we managed to test 75% of

our TB patients, because the TB and the HIV programmes are done by the same nurse, because there's only one professional nurse.

At Gateway Clinic in town we've got a special room for TB patients and we've got a special container for HIV patients. Our testing rate of TB patients is 29%; this is the difference of having two separate rooms for TB and HIV. And of those TB patients that test, 66% test HIV-positive, showing the huge importance of doing those testings.

Decentralised ARV Provision

With an ARV decentralised model, the first advantage in terms of outcomes is the enrolment. The graph (see Figure 4) represents the enrolment per quarter, so in the first four months at the hospital, eight patients were recruited. At the clinics, 59 were recruited, because the clinic started three months before the hospital. So, basically, at the end of quarter one, the hospital recruited eight patients.

And then the hospital and the clinic were more or less working at a parallel pace of recruiting new patients, quarter by quarter. But then after the first year the hospital reached a plateau and basically carried on recruiting the same amount of people month by month. Whereas, at the clinics, after a slight dip, it started shooting up. The space for faster enrolment is shown by the faster recruitment at clinic level. One of the reasons is that at clinics – we've got 12 clinics – each one of them has to recruit about eight people per month. That means you can distribute your work load over many more people than at the hospital, where you've got an ARV-specific clinic, where you've got limited staff.

ENROLMENT

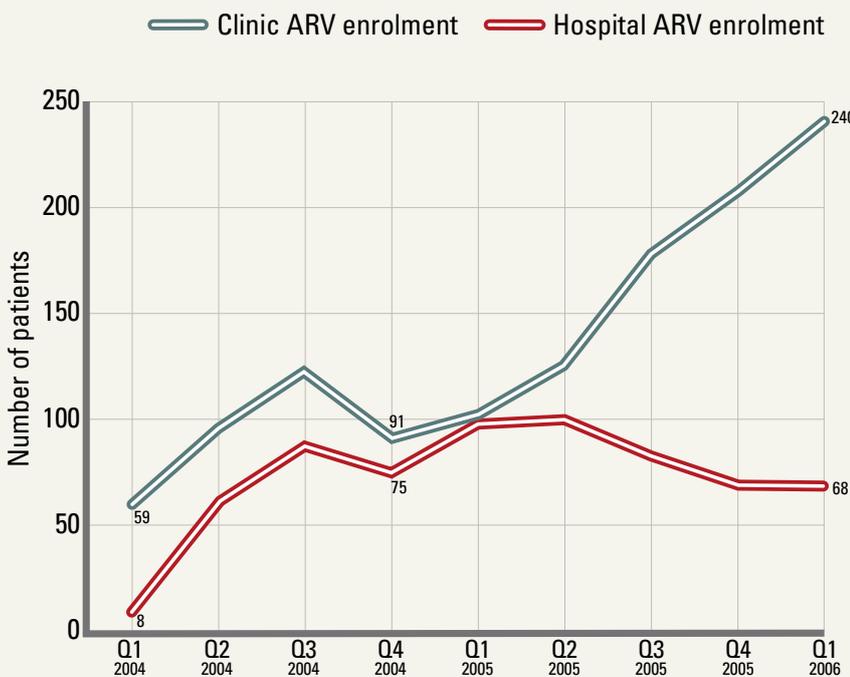


Figure 4. Clinic ARV enrolment is currently outstripping hospital ARV enrolment.

Clinical Outcomes: Clinics and Hospital

	CLINICS	HOSPITAL
Patients	595	430
Still on ARVs	483 (81%)	289 (68%)
Deaths	100 (17%)	58 (13%)
Lost to follow-up	13 (2%)	83 (19%)
CD4 > 200	87%	75%
VL undetectable	90%	78%

Table 1. Outcomes of patients who completed 12 months of ARVs.

Comparing Clinical Outcomes

This table (See Table 1) shows the clinical outcomes of the first about 1000 patients starting ARVs. These patients were chosen because they started in the first 18 months and all of them have now completed 12 months of treatment. At the clinics, it

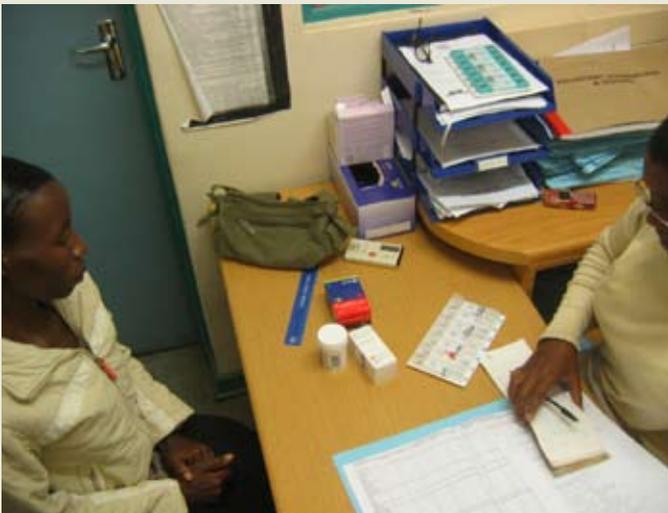
Lessons from Lusikisiki



1 Decentralised ARV provision through primary health care results in greater enrolment figures.



2 TB and HIV services can be integrated successfully.



3 Task-shifting spreads the work load between doctors, nurses, support staff and the community.



4 High community participation results in destigmatisation and better adherence rates.

was 595 patients; at the hospital, 430 patients. Of the clinic patients, 483 are still on treatment at the clinic, which represents 81%. At the hospital, it's 68%. I have included the patients that were transferred out and that are still on treatment, and they represented 6% at the clinics and hospital.

At the clinics we had 100 deaths. At the hospital we had 58 deaths recorded. At the clinics we had 2% of patients who were lost to follow-up. At the hospital we had 19% lost to follow-up and we know that a lot of these patients actually passed away, but it wasn't recorded. So the record-

ed deaths could have been higher at the hospital, but we haven't got those exact figures. After 12 months, 87% of clinic patients had a CD4 count above 200 and 75% of hospital-treated patients had a CD4 count of above 200. In terms of detectable viral load, the best indication of adherence: at the clinics

90% had an undetectable viral load, compared to 78% at hospital level.

So for me, that is quite convincing data of the superior quality of the clinic-based programme. I also believe that the patients dancing with

their ARVs at the support group are happier if they don't have to pay for transport money – the main constraint of having to go to a hospital-based system.

constant at about 50% vacancy level, our workload started at 29 patients per nurse per day in 2004 and is now 47, compared to an Eastern Cape average of 26, taken from the Health Systems Trust statistics, and the SA average of 25.5 patients per nurse (see Figure 5).

Small Decision: Huge Impact

Obviously there is a huge belief in the community that the hospital is better equipped, has got doctors and that it is better. But in Lusikisiki we were getting support for the clinics because of the cheaper access to them and their immediacy for the patients. Then came the directive that only doctors are supposed to initiate people on ARVs and suddenly the patients said, "Well, then we might as well have to go to the hospital if we have to wait at the clinic." So a small decision can make a huge impact on the image of the programme.

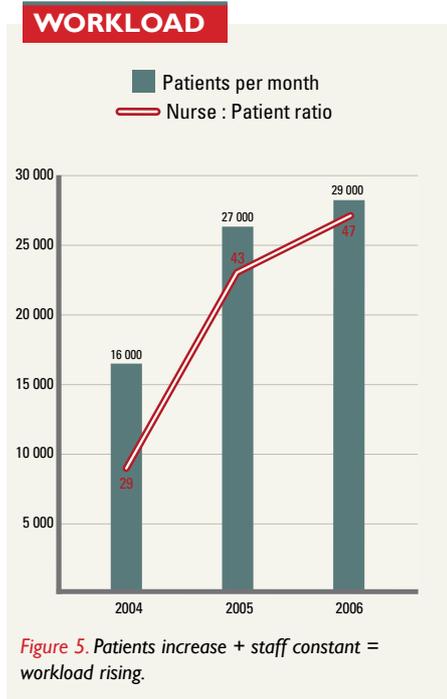
Our main constraint at clinics is that the patient number increased from 16 000 seen per month to 29 000 seen per month this year.

With the nurse numbers staying

Task-Shifting and Down-Referral

So to deal with the backlog, or the shortage of staff, we have to do task-shifting. There are no doctors permanently at the clinics, so the nurses have to do the initiation, the counsellor has to do the preparation, community health workers have to be trained as assistant pharmacists and the community has to be involved to help the clinic to develop the services to bring the sick patients to the clinic, and to educate people about adherence.

There's a big issue in the Department of Health about down-referral and I appreciate it because it starts recognising the role that clinics can play, but I think we need to look



LONG WAIT: Patients queue for health services at a district clinic in Lusikisiki.

THE FUTURE

Moving Forward Depends on Policy

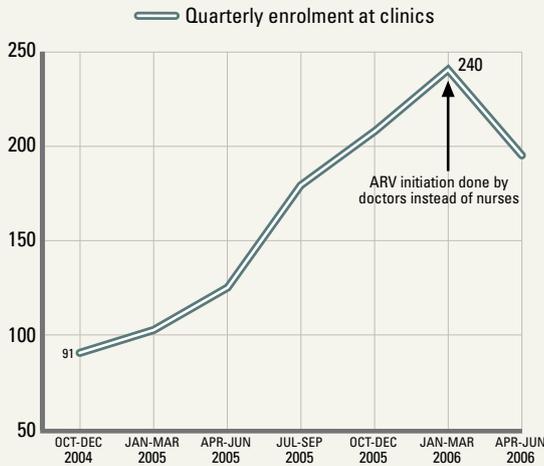


Figure 6. Enrolment figures dropped after nurses were stopped from initiating ARVs in early 2006.

Projections For Achieving and Sustaining Universal Access

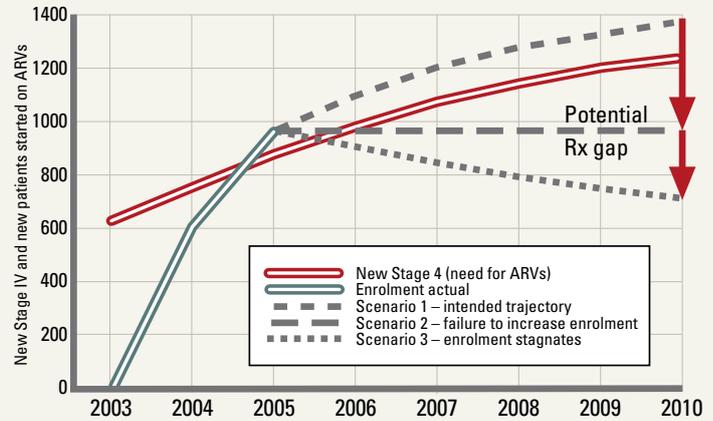


Figure 7. Three enrolment scenarios using the ASSA model.

at clinic-initiated ARVs. The mere fact that people have to start in the hospital is a bottleneck and it doesn't help with adherence, because as soon as the hospital doctor wants to down-refer a patient, there's a breach of contract. Or the patient gets used to a system and suddenly you want to expel them from that system. So we need to start at clinic level immediately with initiation.

This is what happened (see Figure 6). That arrow points at the time when we were told in Lusikisiki nurses were not allowed to initiate ARVs anymore, and then the next quarter our ARV intake dropped.

Looking forward

This graph (see Figure 7) relates to the previous graph and shows not how many people are on ARVs, but how many people get initiated month by month. So, initially we initiated few people. Now we are initiating about the need that exists in our community.

The need is modelled with the Actuarial Society of South Africa (ASSA) model as having to recruit in Lusikisiki about 1000 patients per year. If you continue with the present rate we might make our aim of universal access, but with this dip that

we saw in the last quarter, we must make sure that it doesn't continue going down, because the treatment gap is going to increase unless we manage to carry on recruiting more patients every month.

So I believe there are a few policy issues that are central to the success of sustainability of Lusikisiki: decentralised ARV initiation, task shifting (especially nurses to initiate ARVs), community health workers to do HIV testing and more staff for primary health-care level.

ABOUT THE SPEAKER

Dr Hermann Reuter is the co-ordinator of the Médecins Sans Frontières (MSF) HIV programme in Lusikisiki, Eastern Cape. Reuter was born in Namibia, but grew up in South Africa. He studied medicine at Stellenbosch University and has worked as a doctor in South Africa, Namibia and Botswana. In 1999, he joined the Treatment Action Campaign as a provincial co-ordinator for the Western Cape. In 2000, he joined MSF and worked on the MSF Khayelitsha project, the first NGO project to provide ARVs in South Africa. Seeing the need for a rural model of care for HIV and AIDS patients, Reuter proposed, and co-ordinated, the MSF project in Lusikisiki. After officially handing over the project to the Department of Health in October 2006, Reuter plans to take a holiday along the east coast of Africa before deciding on future work.



Delivering a Rural Model

DR HERMANN REUTER has lived and breathed the rural Eastern Cape area of Lusikisiki for four years, since he founded the Médecins Sans Frontières project there.

Before Lusikisiki, Reuter was involved with the groundbreaking MSF Khayelitsha project, the first NGO-run ARV project at a government facility in South Africa, established in 2001 at a time when public-sector ARV treatment was still illegal.

Despite the tremendous success of the Khayalietsha programme – it was chosen by the World Health Organisation as a model of best practice in 2003 – something nagged away at Reuter’s mind.

He told his colleagues at MSF that a separate model needed to be developed for rural districts. “Seventy percent of people in SA make use of rural clinics and it is a different ball game,” he argued. The model would be based on a decentralised approach, where primarily nurses, instead of doctors, would manage the programme.

At first some of his colleagues were not convinced. “They said MSF is not here to provide services in the country; we are here to have a demonstration model.” But Reuter argued that a rural model was significantly different, and the lessons could be taken to other countries on the continent.

Reuter eventually won MSF backing, but it wasn’t until Nelson Mandela visited the Khayelitsha project that political will met the NGO’s commitment. Mandela said, “This is great, but can’t you do something like this in the Eastern Cape?” recalls Reuter. “MSF said, ‘That is exactly what we are thinking about, will you fund it?’ And he said, ‘yes’.”

MSF then received a commitment



REASON TO CELEBRATE: The MSF’s ARV delivery project was handed over to the Eastern Cape Department of Health in October 2006.

from the Eastern Cape Department of Health’s Nomalanga Makwedini. “We agreed to have a verbal agreement,” he says. By October 2003, Reuter had a written confirmation from the government to start ARV treatment. “It was about two lines,” he recalls.

Reuter says the model of care his team developed over four years is not complex. “I don’t think those are difficult things,” he remarks. “There’s nothing extremely difficult in what we did. What is different is that we had the independence to do what we know is right, without waiting for government policy changes each time. However, to keep the programme sustainable and to role it out to other areas, policy changes are urgently needed.”

He also attributes some of the success to the lessons learned from other MSF projects.

“As an international NGO, you come with that experience. You can come to Lusikisiki and say, ‘I have experience of 10 countries.’ I have only visited one of the other projects, but we can read about them; we hear about the debates. There is tremendous knowledge to help you find your way.”

Four years on, Reuter says the change in the community’s spirit is immeasurable.

“Many people saw HIV as something coming from the ancestors, poisoning, or bewitchment. By providing treatment, people can see there is an answer to this, so it isn’t bewitchment. ...

“In Lusikisiki there are no secrets. If you get carried out of your house on a stretcher to a car and the car takes you out to hospital, the whole community knows about it. If you come back on your two feet walking, and say, ‘I was saved by ARVs,’ that is powerful.”

He’s confident that the programme will continue to be a success long after MSF’s departure. “At the moment I’m bored in Lusikisiki,” says Reuter. “These last two months I didn’t see [ART] patients. Because I wanted to show to the patients that the services go on even if I’m not there.”

“I’m bored in the office, writing reports. It’s not fun for me,” he chuckles.

Reuter is planning to take three months’ leave and cross more borders. “I’m going to Ethiopia ... I’m driving up to Malawi and Kenya and seeing the countries. I want to take a break and then work in Ethiopia.”

“In Lusikisiki there are no secrets.”



Phambili nge-ARVs!

The story of Lusikisiki's first ARV recipient

I AM AKHONA NTSALUBA. I come from Cala, but I stay in a rural area called Lusikisiki, in the Eastern Cape. I was diagnosed HIV-positive in 2002. In hospital, I was advised that I should be sterilised, because I was told that all my children would be HIV-positive. I didn't know anything then.

I was also supposed to have an operation for piles, but I couldn't do both because I wasn't well enough. I was sterilised and stayed in hospital for a few days, then went home.

The sores on my private parts I'd had came back and this time they were bad. I told my aunt. She took me to the hospital and afterwards took me to her house. She took care of me till I got better.

I want to thank the Ntsaluba, Ndungane, and Mthali families, because they all took care of me. My mother and father have also been very supportive.

At the end of 2002, I went to the Médecins Sans Frontières (MSF) clinic in Khayelitsha, Cape Town, which my aunt's friend introduced me to. I told them that I was living in

Lusikisiki. The doctor was concerned that I would be going back to an area where ARVs were not available, but I went anyway.

In 2003, I joined the Treatment Action Campaign (TAC) in Lusikisiki and luckily enough, MSF was there, working very closely with the TAC.

In my work for the TAC, I was educating people about VCT, CD4, PEP, TB, rape and ARVs. One day, I decided to do a CD4 count; the result was 151. I was scared to start ARVs.

But on December 10 2003, I took my first pill, which was given to me

by Nelson Mandela himself. I was so happy to see him taking a political lead on ARVs and believing that ARVs can save people's lives.

In my room, I kept a poster of Mandela as a reminder to take my ARVs. I took him as my ARV supporter.

The last time I did my CD4 count, it was 860 and my viral load was undetectable. I am healthy and I am taking AZT, 3TC and Nevirapine. I have gained weight since 2003.

I thank MSF in Lusikisiki for saving people's lives in a rural area. We will always remember your good work.

We need more people like Madiba,

TAC and MSF, to fight the struggle of HIV and AIDS in South Africa.

Phambili nge-ARVs! (Forward with ARVs!)

“On December 10 2003, I took my first pill, which was given to me by Nelson Mandela.”

Forming Successful Partnerships

Right to Care Clinical Director Dr Kuku Appiah

MY NAME is Kuku Appiah. I'm from an organisation called Right to Care. It's a non-governmental, non-profit organisation that was formed in 2001, but has been operational since 2002 and our aim is to increase the access of people to safe, affordable and effective ARV therapy.

Our sources of funding are mainly from grants from the United States government through the President's Emergency Plan for AIDS Relief (PEPFAR) programme, and we also have a private income that we earn.

Most of the work that we do is through partnerships, through the formation of successful partnerships with the government, with other NGOs and community-based organisations and with the private sector. And one of our specific aims would be to target people who – for one or another reason – haven't got access to antiretrovirals.

We work in the urban, peri-urban and in the rural setting and I'll explain to you further how we do that. We would regard ourselves as a well-established organisation. We are currently the largest in-country recipients of PEPFAR funding and we support six NGO treatment sites. We also support workplace and indigent patient programmes.

We use the provision of ARVs as our focus target and use other support pro-



grammes – such as VCT, training and the use of doctors, who are treatment experts, and mobilisation and also our data management and research – as supportive operations to achieve our outcomes. Through this, we strive to provide a comprehensive service to our target populations.

Five Methods

We currently have developed five methods of delivery of ARVs and

service delivery and our philosophy is that no one method is going to fit for a specific community or a specific group of people.

We want to be very flexible in the way that ARVs are distributed to different groups of people, because people's needs are different and people are different in their geographic location.

We have partnerships and memoranda of understanding with the Northern Cape government,

the Gauteng government and the Mpumalanga government.

Successful Partnerships

Currently our most successful activity is in the partnership we have with the Gauteng government at Helen Joseph Hospital, where we have used a significant amount of funding to build a state-of-the-art, purpose-built ARV clinic with all the space required for counsellors and for patient education, with the pharmacy as per requirements.

We've also used our funding to recruit doctors, nurses and fund NGOs to do counselling in this clinic, and we would like to view that clinic as a demonstration model.

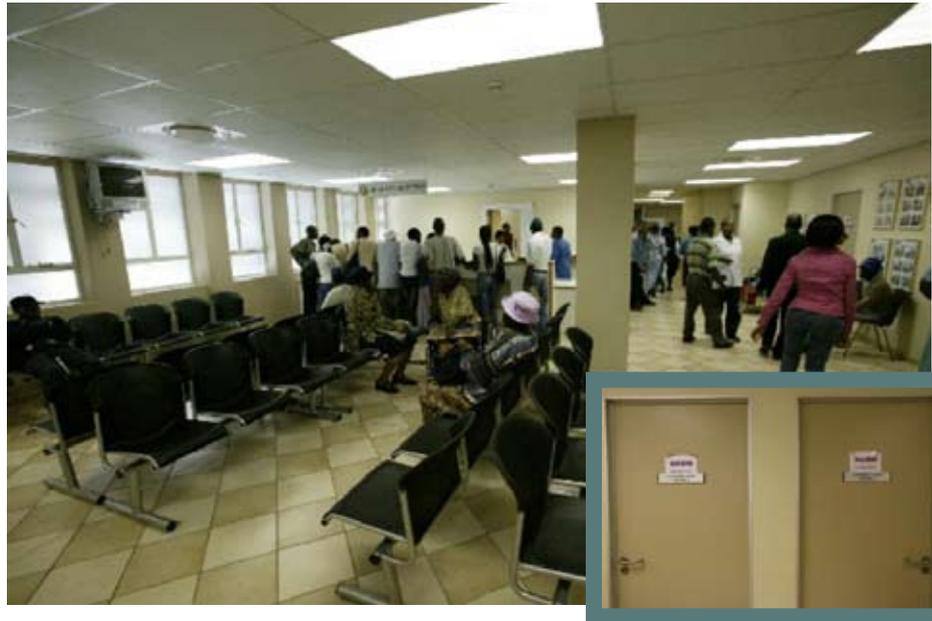
We do have major constraints in that clinic. It is currently bursting at the seams after two years of being in operation. There are 6 000 patients on treatment and no specific plans for the down-referral – so that's a good and a bad story at the same time.

We have partnerships with NGOs. Our model is that we wouldn't go to a community and set up a clinic *de novo*, we would want to find out from communities what is being done there and seek to support doctors who are working or health-care workers who are working in clinics that have already been established in the community.

We are not very prescriptive in the way that those clinics are run. We would try to set specific targets in terms of patients treated or receiving care in order to meet our donors' wishes, but in terms of the day-to-day running of the clinics and the way that the funds that we give to the clinics are used, we are not very prescriptive in that sense, because we understand that we cannot know every community and be able to prescribe how many times a clinic should operate or other such things.

We have partnerships with the

“There are 6 000 patients on treatment and no specific plans for the down-referral – so that's a good and a bad story at the same time.”



STATE OF THE ART:Thembalethu Clinic at Helen Joseph Hospital is the largest ARV delivery site in Gauteng. INSET:The counselling rooms are clearly marked.

private sector. We have a programme that we run with a financial services company where employers pay for their ARVs and we also fund private practitioners to see patients in different communities.

Helen Joseph Hospital

Our clinic at Helen Joseph Hospital has over 6000 patients on ARVs and this photo (see above) is of the patient-waiting area. The bottom two doors are counsellors' rooms, so it's demonstrated that ARVs can be successfully delivered in this sort of environment with a big label put outside saying "Rollout Clinic", and people haven't got any problems with accessing care.

But what also challenges us, is what to do, because all the patients who are receiving treatment here will continue to receive treatment, and how do we move these patients or down-refer patients, so that other patients can pass through the bottleneck?

Doctors

The doctors that we

employ in the clinic are all tasked to work in this clinic for a period of time and then to move – say for six months – out to the other rollout sites within our network.

So all the doctors have an understanding that they will not be permanently based at a specific site but would be required to rotate and provide services to different sites.

In terms of the salary of the doctors, we are trying to keep our salaries very closely aligned to government salaries so that we don't create some sort of inequity. But then we do find it's much easier for us to recruit people than it would be for the government at the same or similar salary scales.

White River

This is one of our clinics that we support in White River in Mpumalanga. This is a well-established clinic under Dr Margie Hardman, who's a shining light in the ARV care and provision arena, and we just support it with funds to be able to purchase drugs.

The aim for their clinic is to be accredited to the government programme, and to continue providing their care with the support of the government in terms of the provision of drugs and lab services. They run a very comprehensive service, with home-based care provision, hospice



services and a lot of training and support groups running from this site.

Wynberg

This is our own clinic that we established in Wynberg, next to Alexandra township. It's in an industrial area. We employ staff there, provide their medication and pay for the laboratory services to provide care for people that live in Alexandra township.

Mobile Delivery of ART

And that's one of our mobile vehicles (see photograph on right). One of our modes of delivery in Mpumalanga is to use this mobile vehicle to access farm communities which are quite rural and a lot of these large farms have small clinics – it's commercial farms that have clinics on their sites – but no health-care workers at all.

So we provide VCT to these different sites. The normal pattern would be that the van would go to a site with a nurse and a doctor once a week and we initially provide VCT and, as people feel more comfortable, we are able to provide ARVs to people using this mode. This is more like a demonstration of the viability of providing ARV

to remote communities that don't have established health-care systems and it seems to be fairly successful. The 1000 patients on ARVs are the patients who are funded by their employers.

Thusong

The Thusong programme is a programme where we ask general practitioners to see a specified number of patients, say 50 patients, who attend their rooms, who don't have medical aid and don't have access to ARVs currently through one of the rollout sites, and we then pay for the service and pay for the medication and the laboratory services.

We've got over 700 patients receiving treatment through this programme and as soon as patients are



DELIVERY IN ACTION: Right to Care offers mobile treatment and care to farm communities in Mpumalanga.

able to access treatment, say through the government site or through a medical aid, we would ask those patients to transfer to that site and let this opportunity be available to people who cannot currently access treatment.

ABOUT THE SPEAKER

Dr Kuku Appiah is clinical director of Right to Care, and has been with the NGO since 2002. She studied medicine at the University of Zimbabwe and subsequently studied to become a specialist physician at the University of the Witwatersrand. Appiah saw her first HIV patient as a medical student in 1986. At Right to Care she co-ordinates programmes around clinical decision-making, ARV provision, VCT and training. Before joining the NGO, she ran her own private practice in Krugersdorp.

Supporting ART in Rural Health Facilities

Dr Doris Macharia, International Centre for AIDS Care and Treatment Programs

WHEN WE started activities as the International Centre for AIDS Care and Treatment Programs, a programme built out of Mailman's School of Public Health, Columbia University, New York, we came to the Eastern Cape and I remember distinctly meeting Mrs Nomalanga Makwedini, from the Eastern Cape Department of Health (EC DoH). There was a great need to go to rural areas in the Eastern Cape. I met Thembi Ntlangulela (EC DoH) and also Dr Hermann Reuter from Médecins Sans Frontières (MSF) and we discussed how we would support rural communities there.

The sites that were identified for us to begin supporting were in the Qaukeni and Mbizana areas. There was St Patrick's Hospital, with its identified clinics, and Holy Cross Hospital.

A 'Different Programme'

This was a different programme for us, as a university, because, just like with most other universities, we largely provide technical assistance and research programmes, and we were funded distinctly for ARV services and ARV drugs.

Of course, when we came to the province we realised drugs were not



the problem and that the government was going to supply them, so we were just going to support ARV services. But, of course, this soon turned out to be something else because obviously the need has been great.

I will talk around activities that we support in the rural areas of the Eastern Cape. I would also like to mention what else we are doing in other parts of the Eastern Cape, in the more urban and peri-urban facilities.

Our approach to implementation has really been to provide a comprehensive care and treatment service

through the implementation of a family-centred service, and this is our core vision. When we came to the Eastern Cape, the things we identified were:

- Infrastructure development, whether it's renovations or putting up new clinic structures;
- Lab and pharmacy support;
- On-site clinical mentoring and training;
- HIV adherence support through the implementation of some innovative strategies, such as peer education programmes; and

- Patient medical record and data collection management.

So this has been our approach. As you can see, it's as comprehensive as possible, but it doesn't mean we get it right at all times. We try as best as possible with the funds we have to try and see how best to provide all these services in the areas where we are.

Successes

Some of our successes have been rapid enrolment, the supporting and promoting of the down-referral of ART services to the primary health clinics (PHCs), the development of local partnerships, building the capacity of clinicians to manage patients, HIV information systems and the creation of clinical space.

So, in terms of enrolment this is the accumulative enrolment of HIV into chronic care and also ART for all the sites that ICAP is supporting (see Figure 1). By the end of June this year, we were supporting about 16 000 people in HIV. That is, those patients who are coming into the clinic get their CD4 count and get cotrimoxazole. And about 6 000 or so are on ART, in all the facilities that we are working in, in the Eastern Cape.

Primary Health Care

Turning our attention to Mbizana and Flagstaff. The graph (see Figure 2) shows patients who are initiating treatment at St Patrick's Hospital in Mbizana, which is a very poor rural community. By the end of June 2006, there were an estimated 600 patients on treatment. We can see in this graph that 52% of patients were being managed at PHCs. A lesson we have learned working in the same district as Hermann's group is that the hospital enrolment is not as efficient as that of the PHCs. And this is primarily because there are more primary health-care facilities involved in patient recruitment.

For example, in St Patrick's we have about four PHCs that are involved, thereby relieving the burden of having one PHC managing all the 300 patients. Each PHC is managing about 100 patients, some 50 and others much less, and this has been quite

encouraging. And we have demonstrated similar results in Holy Cross Hospital, which is in Flagstaff.

Holy Cross Hospital has about 50% of the overall patients recruited in that particular area, and three of the PHCs which have been identified with Holy Cross have also recruited approximately 200 patients.

We can see from this graph (Figure 3) that PHCs are able to get quickly recruited into ART management. When the programme started at the end of May 2005, it was hospital-based. And then by around September/October, like in Holy Cross, the primary health-care facilities were recruited as part of the treatment service point.

We can see the PHCs are really taking off and it is likely that we are (hopefully) going to have similar findings to what MSF has demonstrated in Lusikisiki.

Local Partnerships

In terms of the development of local partnerships, one thing we realised when we came in is that even if we

have all these funds from PEPFAR, we cannot do it alone. So we had to look for local partners to address the human resources issue.

There was just a great need to support clinics (and initially the hospitals) with doctors, nurses, community health workers and some pharmacy staff. Most of this is done in partnership with the Foundation for Professional Development (FPD). This is a new partnership and, hopefully, in the next two weeks, we're going to have the four doctors, four professional nurses and two enrolled nurses and these other local partners, who we are working with, to be able to meet the need for local staffing outside.

Capacity Building

In terms of capacity building we've worked mainly with local partners such as the FPD to conduct basic HIV training. We've also identified local pediatricians based in East London and at Stellenbosch University to facilitate pediatric HIV training for health-care workers.

ENROLMENT

About 16 000 people have enrolled in HIV care, and over 6 000 people in ART, at ICAP-supported sites in the Eastern Cape (see Figure 1).

The number of patients initiating at PHCs now rivals that of hospitals (See Figures 2 and 3).

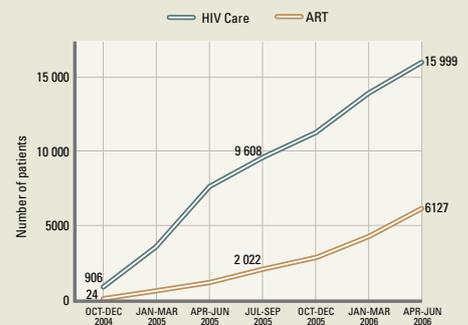


Figure 1. Cumulative enrolment in HIV care and treatment at ICAP-supported sites, Eastern Cape.

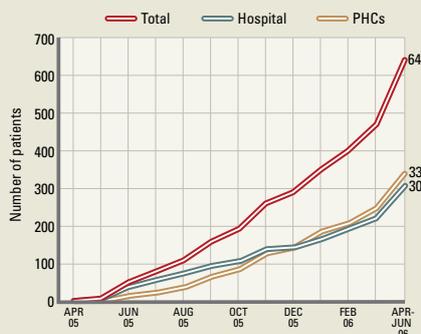


Figure 2. Patients initiating ART at St Patrick's Hospital and four PHCs, May 2005 – June 2006.

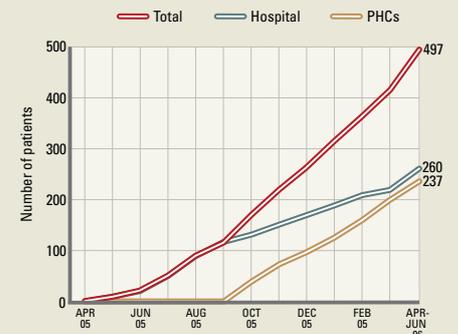


Figure 3. Patients initiating ART at Holy Cross Hospital and three PHCs, May 2005 – June 2006.



In addition, we have monthly clinical mentoring activities in collaboration with Stellenbosch University, through their Ukwanda rural initiative, where experts and local consultants e.g. neurologists, dermatologists, etc, come and spend about three to four days in Mbizana, Mzimkhulu and Flagstaff to provide clinical support to nurses and doctors.

This has been quite interesting and has proved to be a good way of providing support by working with local institutions.

And finally, we have also collaborated with MSF to conduct HIV training for medical doctors in Qaukeni.

Project Management Training

I also want to mention the last area is capacity building: project management training. This really was not what we thought we were coming in to do, but this was a need and an issue that came up time and time again from where we are working. We realised that we had to support putting together project management train-

ing where ARV site co-ordinators are able to come and learn how they can be better managers, how they can improve their own reporting skills.

Information Systems

In 2004/5 we were able to participate in the development and implementation of a paper-based system. We were able to work with the Department of Health to come up with pre-ART and ART registers, which have been pretty good in terms of being able to just capture very simple data elements at the hospital and clinic level.

We have a total of 22 data staff and that tells you how much work is being done. This is one of the strategies we are using to task-shift. Hopefully in the future we will have a computerised ART module. We don't know

how it will be used in rural areas, but it needs to get to that level, especially where we have facilities that have about 1000 or so patients on treatment. The paper-based system may not necessarily be the best way to capture data.

Infrastructure

The infrastructure: when we came, we did not fully realise the extent of need for clinical space. To this end, we have been able to support the installation of prefabricated buildings, some of considerable size in some of the health facilities where we are working.

Unfortunately, due to funding restrictions, we are unable to continue supporting the installation of clinical space.

ABOUT THE SPEAKER

Dr Doris Macharia is the country programme director (SA) for the International Center for AIDS Care and Treatment Programs (ICAP), Mailman School of Public Health, Columbia University.

Macharia oversees the development and implementation of HIV care and treatment programmes in the rural, peri-urban and urban communities in the Eastern Cape and KwaZulu/Natal. Prior to joining ICAP in 2004, she worked with the US Centers for Disease Control and Prevention in Kenya.

Enabling Factors

One of the enabling factors has been the fact that there are existing national and provincial guidelines. I think these act as a good base and I think it is important for me to say that. The other is the close collaboration with the Department of Health, both at local level, and at provincial level.

I think that has been really good for us, to be able to respond to some of the needs that are local, and also obviously at provincial level. And then the fact that there are at least some indicators, which have enabled the development of a simple patient information system for the capturing of data, and then the ongoing mentorship and supervision that's focused on clinical staff, and the development of a service continuum, that is a multidisciplinary team with the integration of HIV services. Finally there is need for continuous evaluation and employing quality assurance methods.

From Possibilities to Probabilities

ICAP intends to build on the programme implementation opportunities that we have already identified.

One is integration of HIV care

ENABLING FACTORS

- Existing national and provincial HIV plan provides overall guidance.
- Close collaboration with ECDoH, CDC and implementing partners.
- HIV indicators available to enable development of simple patient information systems for data capturing.
- Ongoing mentorship, supervision and focused training of clinical staff on HIV/AIDS issues with the intent to develop local expertise that will sustain programmes over time.
- Development of a service continuum that focuses on multiple entry points into care.
- Continuous evaluation and employing quality assurance methods to improve programme (including the feedback of enrolled patients).
- Task-shifting.



programmes with programmes such as TB and PMTCT. This is something we need to get on with very quickly as this is an area where we are likely to see a reduction in pediatric HIV infections and also enrol more eligible TB/HIV co-infected into the programme.

One, of course, is task-shifting, as we've all been talking about: working with registered nurses to prescribe and dispense ARVs, ensuring the peer educators are able to counsel and test, and then making more use of the data collectors to assist the professional nurse in recording the clinical encounter so that the nurse is not over-burdened. (You know, she's testing, she's counselling, she's doing the BPs, she's now also filling in the registers.) I think we can easily shift that task to people who are probably affordable and available, but, of course, clear scopes of work are needed so that there's no clash, and people don't feel that their jobs are being taken over.

I was told this morning that there is nothing like pharmacy auxiliary workers, but, you know, training of pharmacy auxiliary staff as pharmacy assistants, basic training and post-basic training, so that they are able

to absorb the programme and then a more robust data-collection system: that is needed.

After all or most of these identified issues have been addressed, and after we integrate HIV-related services, we need to start thinking about the next opportunity that needs to

be addressed, so as to improve HIV services. We need to start thinking about operational research to answer questions regarding our programme implementation. These questions need to be answered in scientific ways so that we are able to know what really works.

“I keep saying the only thing that's sustainable is HIV itself.”

Challenges and Questions

I was asked: what are some of the challenges and questions? One is, how do we ensure programmes are sustainable and how do we measure sustainability?

This has really been difficult and I keep saying the only thing that's sustainable is HIV itself. We have to do something.

And then what strategies can be adopted to decrease staff attrition and to attract more health providers? Some we've already mentioned, but is that all?

The Business of Treatment

South African Business Coalition on HIV/AIDS CEO Brad Mears

THANK YOU for allowing me the opportunity to discuss where we are with regards to a private-sector contribution to treatment. My presentation won't rotate around treatment in the funded arena, i.e. through medical aids and the like, because I think that is quite a different topic and maybe it's an issue that needs to be treated and discussed through policy development.

An Overview

But I'll give you a macro overview of where the private sector's come from in respect to treating workers in the workplace, and then gradually starting to extend its programme out into the communities. I think that perhaps one of the biggest successes that has been achieved in the private sector is realising that you can treat patients in the private-sector environment.

If we look back to where we were in perhaps 2003 or just before then, the private sector didn't see the treatment of workers as its domain; it saw the treatment of workers as primarily a public health-care question and something for government to pick up on. There was also quite a lot of scepticism within the private sector itself, saying that treatment should be the role of government and that the private sector shouldn't treat.

But when information started coming out, through projects such as the Médecins Sans Frontières project itself down in the Western Cape, the private sector started realising that it did have a role to play in treating workers through self-funded programmes.

Breaking the Mould

And so Anglo American broke the mould, so to speak, and decided to start treating workers.

But there is a very, very long way to go. We are now starting to look retrospectively at a lot of the private-sector programmes and we are realising that there's a lot that still needs to be done. We've realised that workplaces are hallmarked by a lack of trust, poor communication and insensitivity to the needs of workers, and so what we've started to witness

in a lot of treatment programmes, for example, is that there's been relatively low uptakes of voluntary counselling and testing (VCT) and consequently low uptakes of treatment.

Challenges

One of the boundaries that we need to work hard on in the private sector – and perhaps this is where we can work much closer with civil society – is the breaking down of the barriers caused by stigma.

In a recent survey conducted by the South African Business Coalition on HIV/AIDS (SABCOHA), stigma was noted as being the biggest impediment to successful workplace programmes and the biggest impediment to the uptake of VCT and ARVs in the workplace.

But there also needs to be a tackling of the policy framework within which the private sector operates with government.

Enabling Change

In looking at the enabling factors in respect to workplace programmes, we've discovered that trust is an absolute keypin around which the

successes of workplace programmes rotate.

The other area that is a major enabling factor is the issue of leadership. In those companies and sectors where we find high levels of proactive leadership, from company CEOs, trade union leaders, and community leaders, we find that the programmes are much, much stronger. Where you find an ambivalent approach being taken by leadership in the private sector, the programmes are consequently much weaker.

Sustainability

One of the things that the private sector has been criticised for recently is the issue of commitment. How long is the private sector going to be committed to treating workers for? I think this is one of the areas where we need to start developing policy and not in isolation, but policy in relation to government.

A benchmark has been set by South African Breweries, which will provide treatment to the worker, to the spouse, to the children, indefinitely after employment. So if the person gets retrenched, no matter when they are retrenched, they will receive treatment indefinitely.

Lessons Learned

Some of the learning that we are discovering as far as private-sector initiatives are concerned is that there needs to be persistent and consistent messaging, in terms of your programme. There is sometimes conflict between the messages sent out within the company environment and what's being sent out in the community. One of the areas, one of the steps that we took to try and harmonise that inconsistency, was for SABCOHA to partner with the Khomanani programme.

As I've already mentioned, the private sector needs to start extending its treatment programmes to spouses and children and then into the community.

The Mpumalanga Highveld test-



“We need to explore the area of public-private partnerships.”

ing and treatment programme is indeed one of these initiatives. It's an initiative that exists in concept at the moment, but an example of where the private sector can play a contributory role in supplementing public health-care infrastructure and indeed funded initiatives like MSF.

There are several large resources companies in Mpumalanga, such as Eskom, Sasol, Xstrata, Isizwe and several other resources companies, that have extensive treatment programmes on site and have the capacity and the resources on site to treat their workers.

The proposal is to extend these facilities for the community to be able to access. One of the restraining factors is the inability for us to structure a partnership with provincial gov-

ernment so that we can provide these facilities to the community at large.

Possibilities

Where are the possibilities? Well, we need to explore the area of public-private partnerships. I think that whilst the issue of public-private partnerships may exist at a policy level, we haven't got enough experience on how these should start taking place at a practical level.

We need to start extending our workplace programmes into the far-flung areas of South Africa and this has only become possible recently with, for example, the changes in the Tax Act, which has affected quite negatively the company's ability to be able to provide self-funded treatment programmes.

In respect of the private sector getting involved in treatment, it needs to view the area of receiving funding from funds such as the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) as something that is in its interests.

Business has by and large done it on its own up until now and it needs to be partnering with other NGOs and CBOs. We need to use foreign funding far more extensively and we need an overhaul of the legal framework to make it much more enabling for employers to test, to make sure, for example, that employees are guaranteed access to treatment.

And finally, we need to move the engagement between business and government from engagement at a national level, down to provincial level, so that we can make sure that these partnerships start taking shape.

ABOUT THE SPEAKER

Brad Mears is the CEO of SABCOHA and has worked at the Durban Chamber of Commerce and Industry since 2001, where he manages the HIV and AIDS programme. Mears graduated with a law and history degree from the University of Natal (now the University of Kwazulu-Natal), and also holds a post-graduate diploma in industrial relations from the same university. His vision is to get people in the business sector to understand that HIV poses a threat to the future of South Africa's economy, but that much can be done to overcome the epidemic.



Task-Shifting in Thyolo

A Treatment Case Study from Malawi

Dr Rony Zachariah, Médecins Sans Frontières

Malawi in Numbers

10-million	Population of Malawi
930 000	HIV-infected people (9%)
90 000	HIV and AIDS deaths per year
25 000	TB cases per year (77% HIV+)

I WAS ASKED by the organisers to give an international perspective of the Médecins Sans Frontières (MSF) experience in terms of task-shifting, but I'm afraid to say I've changed that slightly because I thought it would be more relevant to try to speak about a context similar to one you are working in.

So I decided to choose a sub-Saharan African country, a country in which there's a high prevalence of HIV and AIDS, a country in which we have an intervention that is rural, a country where we have major human resources problems and a country and a setting where we are trying to achieve universal access.

So it's my pleasure to present to you, "Task-shifting in HIV and AIDS care in a resource-limited rural district: some successes and lessons learned from Thyolo District in Malawi". Malawi is a small country in sub-Saharan Africa, with about 10-million inhabitants; roughly one million or one out of every 10 is HIV-infected. The country registers about 25000 cases of TB each year, eight out of every 10 of them are HIV-positive. Seventy percent of all the hospital admissions are HIV-positive and there

about 90000 AIDS-related deaths each year. HIV and AIDS and TB thus constitute a major burden on the health services.

Human Resource Crisis

However, the health services face a major shortage of health staff. Over 50% of all the health staff positions in the Ministry of Health are unfilled. Fifteen out of 29 districts have less than 1.5 nurses per health facility, and when it comes to doctors, there are 10 districts with no Ministry of Health doctor and four districts with no doctors at all. The government of Malawi declared in early 2004 that they are faced with a major human resource crisis and the secretary of health actually declared towards the end of 2004 that the health services had collapsed.

If you look at the staffing per 100 000 population for 2004 and if you compare Malawi with a number of other sub-Saharan African countries, you will see that Malawi is the worst, with 1.1 doctors and 26 nurses per 100 000 population. What is very clear from this is that if you want to roll out HIV and AIDS care and ART interventions, you cannot rely on doctors and nurses to deliver them: what you need to do is shift tasks, down to the communities.

It is against that backdrop that I'm going to take you to Thyolo District in Southern Malawi. Thyolo is one of the largest districts in the country, with 500 000 people, and where the situation is no different. But despite the human resource challenges, we decided to embark on an ambitious task – with the Ministry of Health – in trying to provide universal access for the entire population of HIV-positive people that need ART by the end of 2007.

The objective of this presentation is, therefore, to highlight some of the successes and lessons learned in task-shifting to achieve universal ART access in Thyolo. How did we go about it?

The Thyolo Approach: Testing and Tracking

The first challenge was to ensure that we tested enough people and we knew who we needed to treat. We did this by expanding our Voluntary Counselling and Testing (VCT) services, from three nurse-run sites, to 17 sites run by trained People Living With AIDS (PLWA) counsellors. There was then the need to ensure that our HIV and AIDS clinics were able to meet up with the case load. We thus needed to drastically improve the efficiency of the delivery systems, particularly for ART. And to be able to do that, we needed to change the profile of our clinics, from a one-track, doctor-centred approach to a multiple flow-track system, that involved different cadres. In practice, what this meant was that all regis-



“The secretary of health in Malawi actually declared towards the end of 2004 that the health services had collapsed.”

tered patients would be screened by a nurse and would be allocated into one of three tracks – a slow track, a medium track and a fast track.

You will notice that the human resource cadre in the different tracks, as well as the tasks that are allocated to each of these tracks, are different, and this permitted us to shift tasks, from a doctor to the medical assistant, to the nurse and to the PLWA counsellor. The doctor in Malawi is mostly absent and the clinical officers are mainly involved with supervision and support, and no longer with direct clinic care. We had to also scale up ART counselling and we followed a similar track system for within the health facilities. For groups and individual counselling, we decided we should try to get

them as close as possible to the communities, close to the rural communities, especially when they are distant.

The community has been key in all this and we set up dialogues with pre-existing community support groups early in the process, some of whom were already providing religious and social support. Volunteers from these groups were recruited and trained; we set up formal links between them, health units and volunteers and there are carbon copy referral books that allow tracking of patients. The community volunteers are involved with a number of other activities, including symptomatic treatment of diarrhoea, fever and oral thrush, adherence counselling, support of family care-givers at home, referral of patients who have drug reactions and risk signs to community nurses, cough screening for TB, and various forms of social mobilisation.

The core of the community work is based on the volunteer, who takes care of about 8-12 patients. Trained volunteers receive a home-based care kit, in which you have very basic, material: oral re-hydration salts, TB sol tablets, paracetamol, aspirin, anti-malarials, co-trimoxazole, condoms and hygiene products, to name the main part.

Have Motorbike, Can Nurse

A nurse on a motorbike moves around and supervises 50 volunteers; we have seven nurses in total. The logistics are pretty important, our volunteers have bicycles and the nurses have motorbikes of two types

Staff per 100 000 population

Cadre	South Africa	Botswana	Ghana	Zambia	Tanzania	Malawi
Doctors	69.2	28.7	9.0	6.9	2.3	1.1
Nurses	388	241	64	113	37	26

WHO, 2004

because the terrain is sometimes very difficult.

The Results

What are some of the results? From January 2004 to June 2006, we had tested a total of 73484 people in Thyolo. About three-quarters of all that testing in the district was done by trained PLWA counsellors: this is the impact of task-shifting (see Table 1).

Since 2004, we've gone from a maximum capacity of about 900 tests per month, to an average of over 3750 HIV tests per month. At this rate, we will be able to detect the entire 50000 people who are HIV-positive in the district by the end of 2007.

Task-shifting, therefore, increased our counselling and treatment capacity by at least four times. If you look at the consultations per month, the picture is similar. In 2004, there were about 1500 consultations, using a doctor-based clinical officer system.

Through shifting consulting to medical assistants, nurses and PLWAs, we went up to over 4250 consultations, and we've been able to decentralise to three health centres.

If you look at the ART inclusion rates per month (see Figure 1), you'll see a major difference. In 2004, we had a maximum capacity of 110 inclusions per month and our doctors were saying we were completely overloaded. We did the task-shifting and track system, including medical assistants, nurses and PLWAs in the two same hospital sites, without increasing the staff, and we were able to move up to 350 inclusions per month, 3.5 times the previous number. We've now been able to decentralise to three of the main health centres, to nurse-based inclusions, and, as of June 2006, we have 500 inclusions per month.

RESULTS

ART Inclusions (p/m)

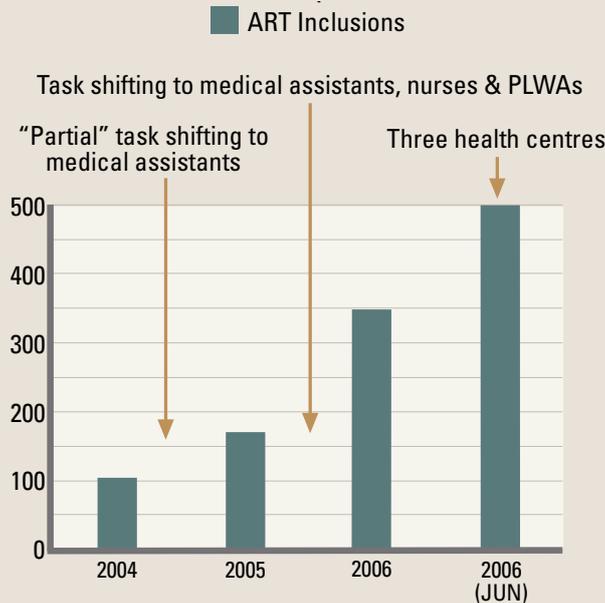


Figure 1. ART new inclusions per month (two main hospital sites). Task-shifting increased ART capacity by five times.

HIV Testing

	People
HIV-tested	73 484
HIV-positive	24 214
Tested by a PLWA counsellor	64 461 (>85%)

Table 1. Over three quarters of all counselling and testing in the district is done by PLWA counsellors. (Jan 2004 – Jun 2006)

ART Outcomes

	Community Care	No C. Care	
Placed on ART	895	739	
Alive and on ART	856 (96%)	560 (76%)	P <0.001
Died	31 (3.5%)	115 (15.5%)	P <0.001
Lost to follow-up	1 (0.1%)	39 (5.2%)	P <0.001
Stopped	7 (0.8%)	25 (3.3%)	P <0.001

Table 2. Comparing ART outcomes among patients living in areas with and without community support (Dec 2004).

The Power of Task-Shifting

So we have achieved a five-time increase in the capacity, in the district, without increasing our doctors or nurses, but by task-shifting. We will achieve universal ART access at this rate, by December 2007. Our target was 10000 people by the end of 2007; by June 2006 we had 4302 people on

ARVs; we have an average ART initiation per month of 500, as of June 2006 and actually we will reach this target by July or August 2007 – in fact, four months before the target we had set for ourselves. I think the important message I would like to deliver is that if we had not moved to task-shifting, and we had stayed on our doctor-based system, as in 2004, we would have achieved this target only by 2013.

Active Case-Finding Delivers Far More Cases

The community is involved with a number of other tasks that we've shifted to them, and one of them is active TB case finding. In every household where there is a TB patient or an HIV-positive individual, volunteers actually screen for a chronic cough, defined as a cough that someone has had for over three weeks.

There were 806 individuals referred with a chronic cough; 161 or 20% of them were found with smear-positive tuberculosis. Now if you assume that the average household size in Thyolo is five, this translates into an annual TB incidence rate, among the households with a cough, of 1997 per 100000, as against the reported TB incidence in Malawi, using a passive case-finding strategy, of 265 per 100000.

There are two important messages here: cough-screening gives you a very high yield of smear-positive TB and this screening is done by community volunteers, and second, an active case-finding strategy will deliver eight times more infectious TB cases than a passive case-finding strategy.

The community makes an average of 422 referrals per month; a great deal of them are actually to HIV testing,

therefore, they actually are a provider for ARV. One in five patients referred to community nurses or to health facilities had problems with starting or with side-effects to ART, or complicated opportunistic infections. So the presence of these volunteers helped us to detect these problems early.

Over a two-year period, between January 2003 and December 2004, we had placed a total of 1 634 individuals on antiretroviral treatment (see Table 2). Of these, 895 came from areas with community support, and 739 came from areas without community support. We decided to compare the ART outcomes among patients living in areas with and without community support. There was a significant difference in standardised outcomes when it comes to those still alive and on ART (96%), as against 76% in areas without community care. Similarly, in areas with community support, there was only one patient lost to follow-up, as against 39 lost to follow-up in areas without community care. And if you assume that all patients who are lost to follow-up are likely to die, you are actually speaking of a five-fold difference in death rates, between areas with community care and areas without community care.

Community Support Key in ARV Outcomes

If you look at the relative risks, it only confirms the significant difference in terms of ARV outcomes in areas with community care. Thus, community support is associated with significantly better ARV outcomes. There is also a social and economic dimension and one must not forget the potential of the community, especially in rural areas, and the contributions they can make.

We have 25 farms run completely by community associations today, but which were supported initially by us and which produce different agricultural crops, and they've also gone into rabbit farming and fish farming. The produce of all these agricultural products go to destitute HIV and AIDS and TB patients. There over 900 orphans, mostly under five years of age, from single-member households, who benefit from pre-school care, today run by the teachers' association of



DOING IT FOR THEMSELVES: Anala and Patricia are orphans who have gone on to start their own tailoring workshops in the Thyolo District in Malawi. They have now started to support others.

Thyolo. Then there are various forms of vocational training for children and orphans over 12 years of age.

Ambitious

We have been told several times that some of these activities are very ambitious, even within MSF, but maybe that's exactly what we want, because at the end of the day, it brings back human dignity and it brings back hope for the future of many children like them.

In summary, what we have learnt from our experience in Thyolo, is that if we want to achieve universal access, we need to develop a structured public health ART scale-up model. We need to keep it simple, we must be inclusive of all the stakeholders and we must use lower cadres and the community.

The choice was pragmatic. We were compelled to act in the best interest of the good for many, instead of trying to offer the best services for

a few, considering our constraints. We need to be innovative and those of us who are policy-makers and decision-makers must be courageous enough to challenge and adapt some of our established practices, rules and regulations. Often, a good deal of these are to do with professional turf-protection, rather than patient safety and patient interest and quality.

At the end of the day, I think we should be judged by what we have done to make a difference to the lives of thousands of people who need our help and how we have adapted our health services to meet their needs.

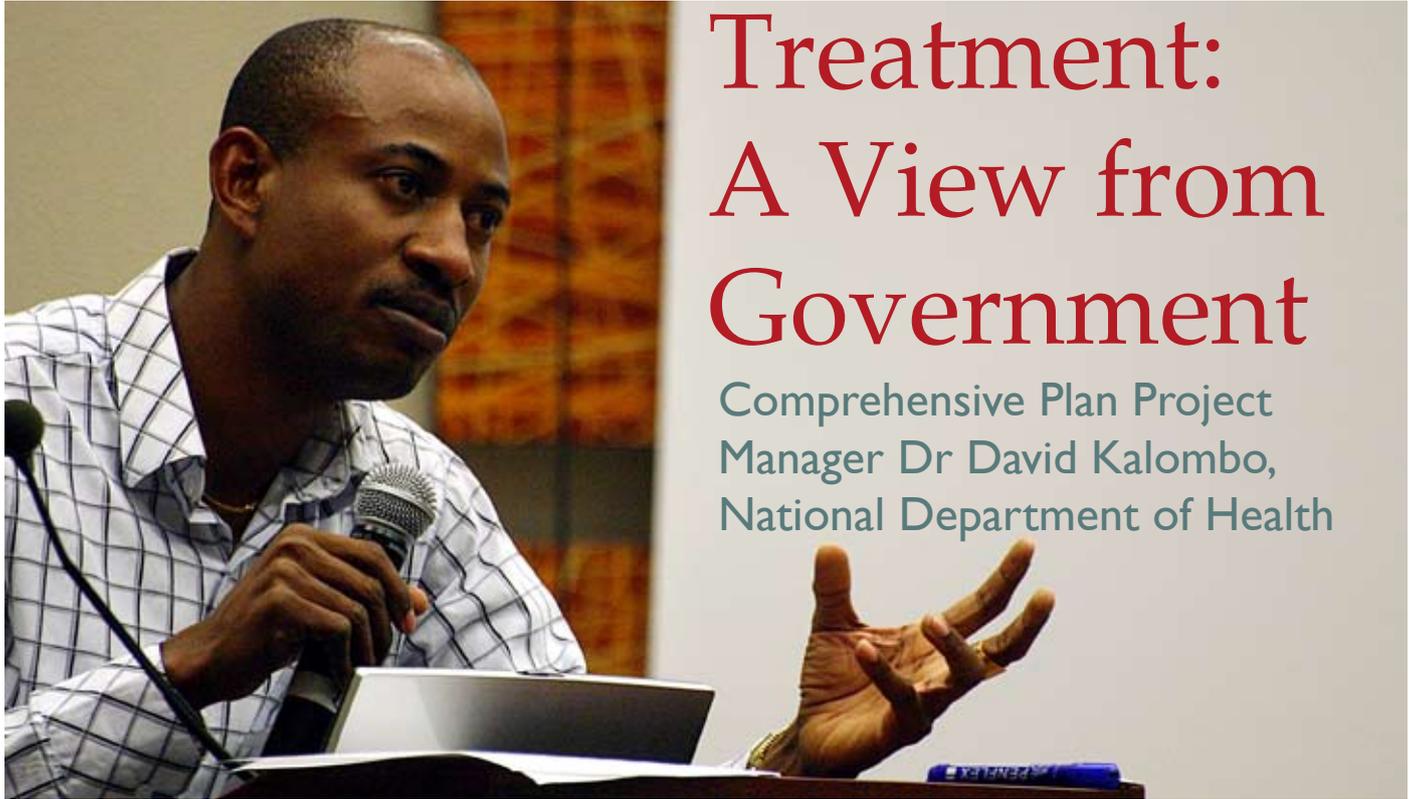
I will leave you with the words of an HIV-positive patient we met in early 2006 in one of the remote communities of Thyolo, and who was in stage four. He actually told us what exactly we needed to do with the health service in Thyolo:

"I underwent counselling in the community and was told by the community nurse that I will still have to present for another repeat session, which must be done at Thyolo Hospital. I left at 3:30 am on foot and arrived there after about four hours of hard walking. I waited in the group counselling room until 12 noon and as I was very hungry and thirsty, left for the market to find something small to eat and drink. On return, I was told that the session was over and I must now return one week later.

"I had to walk back home for another four hours without anything. I must now walk back twice to Thyolo Hospital, once for a group counselling session and then again for individual counselling, before I can hope to get ARV. The nurse tells me, this is all to make sure I am committed to taking ART, but I already know very well that I need antiretroviral treatment and I'm ready to take it, but it just seem so hard to get."

ABOUT THE SPEAKER

Dr Rony Zachariah is operational research co-ordinator at Médecins Sans Frontières (MSF), where he evaluates and documents the work done by the international organisation. Originally from Luxembourg, Zachariah has worked extensively in Africa, as a doctor and a researcher. He is currently based at MSF headquarters in Brussels, Belgium. He studied public health and completed his PHD in Tuberculosis. He has obtained qualifications from the University of Maiduguri in Nigeria, London School of Hygiene and Tropical Medicine, and the University of London.



Treatment: A View from Government

Comprehensive Plan Project
Manager Dr David Kalombo,
National Department of Health

LET ME give you an overview of the Comprehensive Plan on HIV/AIDS and then I'll touch on some of the issues which were raised during the discussion in the morning, and if there are questions, we can discuss them.

Between 2000 and 2005, we developed the strategic plan, which had four main pillars: prevention; treatment, care and support; legal and human rights; and research, monitoring and surveillance.

During the first two or three years, there were a lot of activities or interventions in terms of prevention, care and management, and legal rights. There were still outstanding issues about treatment and it was important that we had an operational plan and a comprehensive approach. And so, the government worked with various stakeholders in the country, to put together the comprehensive plan.

The two pillars of the comprehensive plan are indeed to provide quality care to people infected with HIV and AIDS and to ensure that the estimated 40-million people who are uninfected, remain uninfected. At the same time, we are aiming at strengthening the health-care system.

Since the adoption of the operational plan on 19 November 2003, we have engaged in activities of accredi-

tation. These were initially led by the national Department of Health, and involved officials from the department responding to the call from provinces. The provinces initially identified 32 facilities, for the national department to go and assess the readiness of, in terms of them providing comprehensive care.

Operational Plan

I believe every one of you is familiar with that tool of accreditation which has been revised recently. Maybe just to come back to the operational plan, I expect everyone in this room has read that operational plan, because indeed what we are all talking about is the implementation of that plan and there's no way that we as managers can implement a plan which we've never read. So it makes it difficult for you to understand certain activities clearly if you have never read the plan. I think our president has said that this is one of the best operational plans in the world. Indeed it is, and if

you read it, you will understand why we are saying so.

And so in early 2004, we started this process of accreditation, and the first accredited facilities began providing ART.

At the beginning of every year, we work with our counterparts in the provinces, and we develop business plans. Why are we developing business plans? Just to ensure that the provinces do receive necessary resources, especially financial resources, based on the activities which they have planned or are going to be implementing in the course of the financial year. So we assist our provincial counterparts; we discuss their needs and their activities. So we agree to the business plan, then on a monthly basis we transfer funds to them.

In terms of accreditation, the provinces will do the first assessment of the facility and ensure that the facility is ready, based on the requirement in the tool. Then the national officers will go just to certify. This is has been the process up to now. Why are we doing that? Because we want to strengthen the health-care system, because we want to make sure that when a patient is seen, he or she is being taken care of in a continuum of care and is being given quality care.

For you to provide quality care, you need to make sure that there are activities or interventions in place.

Human Resources are Key

At the same time we're also assessing the current services which have been offered to patients and making sure that there's enough staff and capacity in terms of human resources.

We need to ensure that staff has been trained, there's enough space, there's adequate monitoring systems, there's equipment and the lab system works well, there's enough storage for the ARVs, there are human resources in terms of the doctors, pharmacists, dieticians, lay counsellors, social workers and data-capturers – I will insist in data-capturing, because that's very, very critical.

The reason we're doing all this, is because we want to do things differently. We have serious issues about the Prevention of Mother-to-Child Transmission (PMTCT) programme.

The reason we are insisting that the facility should have a data-capturer is to leave the nurse focusing on the nursing care. Last year, we spent R2.5-million just to do the training of data-capturers, but still we do have challenges in some facilities where the data is actually missing, and there's no way you can manage any programme if you don't have data.

So we are trying to do things differently and to ensure that at the same time we provide quality care and that patients have access, because our target is also universal access.

And talking about universal access, we usually say we're not looking at the number of patients on treatment. We're saying the number of patients is estimated for business development. So if a province wants national to provide funding, of course it needs to have an estimated number of patients they intent to put on treat-

ment. We will then calculate how much the patient cost will be for the year, and then allocate the budget. So this is a process, but the target of government is mainly to ensure that there's accessibility to the treatment for our patients, and we are doing it progressively.

In the first year we set ourselves the target of having at least one service point per district, and we have 53 districts. On March 30 2006, for instance, I did an accreditation in Kuruman.

We were struggling to get that facility started. There were just no doctors, but we managed at last to accredit it.

For the second-year target, we said we needed to have moved into the sub-district.

The first target was that at least 30% of sub-districts should have accredited facilities.

Last year, it was up to 40%. Indeed we had to review our target because we were doing well. At the end of March this year, we had 62% of sub-districts having at least one service point. The current target has now been moved from 60% to 75%. To date, we have 72% of sub-dis-

tricts having at least one service point. We want to ensure that patients everywhere have access to quality care.

Interventions

I will now talk briefly about the interventions. The first one is prevention, or maybe I'll start with social mobilisation. I think we had a lot of activities through Khomanani. Our colleague from the South African Business Coalition on HIV and AIDS (SABCOHA) did mention what Khomanani has been doing. We have all seen the Khomanani media campaign, which has used TV, radio, print and billboards.

It ended at the end of June, but we're working on a new tender, just to ensure that we have a diverse number

of service providers who are going to be targeting all interest groups. Then we also need to make sure that the communities are informed and we can mobilise them, so that they can contribute to the implementation of the comprehensive plan. We have disseminated more than 10-million information, education and communication materials across the board.

Prevention

We have a lot of activities in terms of prevention. I mentioned the PMTCT programme. The Promoting Effective Perinatal Care (PEPC) programme and the Voluntary Counselling and Testing (VCT) programme are also in place. We feel that prevention is the cornerstone of the comprehensive plan, because we don't have a cure and there's no treatment without prevention. This is the World Health Organisation's Year of Prevention, and we are working on an accelerated prevention strategy.

The second important pillar is nutrition-related interventions. This is critical. I've had discussions with many colleagues here who are partners with us in this. We do have partners; some of them have started this provision of ART before the comprehensive plan, where the focus is mainly on ARVs. But we think it's unfair if you just look at the aspect of ARVs and you don't look at the other needs of the patients, which are very critical.

It is important that all the patients should be assessed for nutrition intervention. All patients, wherever they are, and regardless of them qualifying for ARVs or not, should be assessed and should be provided with nutrition interventions. Looking at the needs and the level of poverty, I think it's critical.

Before you provide ART, make sure that those patients are assessed and they can be provided with nutrition interventions, which is also essential in terms of prevention. I think we have provided nutritional intervention to more than 700 000 patients across the provinces.

Another intervention as far as the operational plan is concerned, is traditional medicine. We feel it's important that we understand and

“We are trying to ensure that we provide quality care and that patients have access. Our target is also universal access.”

assist traditional medicine in terms of the research, which we're currently doing with the Medical Research Council (MRC).

Money and funding has been provided to the MRC, to look at the level of efficacy of some plants. We also engage with traditional healers, in their registration and training.

Traditional Medicines

There's the Traditional Medicine Act which came into place in 2004, and very soon we're expecting to have a Traditional Medicines Council. The council will assist us to make sure that we continue training and will assist with other activities for traditional practitioners, so that they understand the provision of ARVs.

We know that 90% of our patients do consult traditional practitioners and often they've consulted them before coming to us.

Staff appointments are another intervention. In this process, what we did, we appointed senior officials to manage this programme at a national level, as well as at the provincial level.

In terms of procuring drugs, we are engaged with seven pharmaceutical services, and R3-billion has been put aside just to ensure the availability of drugs. That has been going well and to date we have enough stock in most of our facilities.

The lab services have been improved. We started with 10 CD4 count machines, and we now we have 42

CD4 count machines. We had three viral load machines; now we have 12. We didn't even have Polymerase Chain Reaction (PCR) testing machines and now we have seven, to make sure that we keep the turn-around time of a test below six days.

Single Information System

We're planning to have a single patient information system, though unfortunately this hasn't really taken off as we expected. We started a pilot of this process in Witbank, and up to now it hasn't been expanded to most provinces.

This means we're still relying on the paper-based system, which sometimes makes it quite difficult to get in data in time.

The last important intervention which I really need to talk about is the pharmaco-vigilance centres. We know that if you use ARVs, you may develop side-effects. So it is important for us to ensure the safety of drugs. There's one at Medunsa, and one at University of Free State and there's this spontaneous reporting which is done in Cape Town.

We have now established three centres and we will increase to five centres and continue in other provinces for the focused surveillance.

There are so many things to talk about. Let me just finish with the financial resources. Because we want this programme to be sustainable, we have made sure that there are enough

financial resources.

Ninety percent of the programmes or projects are funded by government. If we can recall all the expenditure which we have spent in all government programmes or departments, it's more than R11-billion. The budget last year for the component of the ART within the comprehensive plan was R1.1-billion. This year it is R1.5-billion

Let me just finish with the challenges, the biggest of which is human resources. According to a statement issued by the World Health Organisation at the end of 2005, Africa needs about 2-million health-care workers. We, as an African country, are also facing that challenge. We can have many facilities accredited, but we do not have enough doctors, pharmacists, dieticians, and we have space shortages.

Most of our hospitals are overwhelmed, so we need to down-refer patients. Indeed, we have revised the tool of accreditation, so that we have at least begun to down-refer stable patients to clinics.

We're also expecting that we will get the nurse-initiated treatment at the end of the day, so that we can improve the uptake of patients.

But we can only do that if we make sure that there's capacity at the clinics and this is the process which we're embarking on. We need to have capacity in the clinics and once that is established, then we can responsibly down-refer patients to those clinics.



ABOUT THE SPEAKER

Dr David Kalombo is the project manager of the South African national Department of Health's Comprehensive HIV and AIDS Care, Management and Treatment Plan.

Kalombo grew up in the Democratic Republic of Congo and has worked as a medical doctor for 16 years. After coming to South Africa in 1991, Kalombo completed his internship at Groote Schuur Hospital in Cape Town in 1993, and worked at a number of hospitals thereafter, including Sebokeng Hospital, Johannesburg Hospital, Hillbrow Hospital, South Rand Hospital, Edenvale Hospital and Dr George Mukhari Hospital in Garankuwa.

Kalombo has an MBA from the Milpark Business School. He joined the national Department of Health in 2004. "There's no way you will manage a programme like the Comprehensive Plan without communication," he says. "You need to communicate to get buy-in, to improve the way you are doing things. Communication helps to clarify the issues."

He says of ARV delivery, "It's a combined effort and it doesn't help to point fingers. We need the involvement of everyone. We either all win or we all lose."

Questions & Answers



Dr Marga Vintges

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I do agree that the plan, the comprehensive plan, is a huge challenge and I'm very happy with the way it is being implemented at the moment. I really do want to ask you to say something about the rural areas now, because we are here for the rural areas. So we're talking about the guidelines: are they maybe too high for rural areas? Do you not aim, with your accreditation, to create mini-hospitals out there? They don't have to be mini-hospitals, out there in the rural areas, to roll out ARVs. You don't need a fancy building, you don't need a dietician, you don't need a doctor in every clinic.... It shouldn't be a mini-hospital to do proper quality service out there.

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Dr David Kalombo

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It would be nice to read the guidelines; maybe then you can pose a question. If you read the revised accreditation tool, you will understand that there are minimum requirements for both hospitals and clinics. The plan has to be implemented in a primary health clinic. Why did we start implementing the programme in the hospitals? It is because of the capacity and the demand. The guidelines are actually made or produced by many national experts and some are present in this room. As a group we decided that those minimum requirements need to be in place before the facility or the service point is accredited. You need to have qualified and skilled people to provide quality services. There's no other way. You need to have consulting space and a laboratory system. Nutritional intervention is of paramount importance. It is all about team work and people that are ready to make a difference.

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Doris Macharia

“ Looking towards the next couple of years, how do you see accreditation being done differently? Because, right now, I think it’s national. ... Is this really sustainable and is there a way of empowering providers at a local level to be able to look at the services they have and almost accredit themselves, so to speak? Your thoughts on that. ”



Dr David Kalombo

“ We do not have capacity at the national office to reach all places to conduct the accreditation process. The responsibility of accreditation is given to provincial officials. They decide which facility they are going to accredit and then they do the assessment and develop strengthening plans, and once the facility is ready, the national office is invited to certify the site. So there is no way in which the national office can delay the accreditation process. ”



Dr Kuku Appiah

“ This may be more of a philosophical question, but, as good as the comprehensive plan is, how does it hope to actually provide treatment for all the people that will need it, in say, 10 years’ time? Are we saying that the ARV treatment is going to be hospital-based, doctor or nurse-based provision? Are we saying that drugs will always be dispensed from a chemist? Are we saying that we’ll be able to provide treatment for the number of people that actually need treatment by running clinics that operate from eight to four, Mondays to Thursdays? What kind of major shifts in thought process or in working practices are we going to have to embrace in order to actually deliver this kind of health intervention to the number of people that we’re supposed to be delivering it to? ”



Dr David Kalombo

“ I mentioned the revision of the accreditation tool, which will then lead to a nurse-initiated treatment at the CHC (Community Health Centre) and PHC level where there is capacity. So this is where we need to go because we do not have doctors. We have to manage the migration of staff. We have put systems in place to manage scarce skills and provided a rural allowance for people going to remote areas but we acknowledge we still have challenges around that. One critical thing is that we are not going to compromise the quality of care of patients in the clinics. The continuum of care will be at all levels, supported by an effective referral system, and for that we need the collaboration of all stakeholders, including communities. We cannot do it alone. ”



Dr Ebrahim Variava

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My question is about NGOs that provide ARVs. It's going to be very difficult for these organisations to continually provide ARVs on a long-term basis. I'm not too certain if there's any sort of programme to incorporate those patients within the state and support those programmes that are ongoing, on the one hand. On the other, various NGOs may use slightly different regimens in terms of treatment. Some employee organisations are using different treatment regimens. When they come in to the state there are clearly problems with therapy. Are there any plans to sort out these problems in the near future?

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Dr David Kalombo

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There's an NGO, funded by the Elizabeth Glaser Paediatric Foundation, Thembanabantu, in KZN, with which we agreed to go into partnership with. We will be providing the drugs and they will continue with the provision of services. We requested them to support the feeder clinics to allow us to reach more patients. When guidelines are developed they are made available to all stakeholders, in the public and private sector. This is so that there is no confusion among service providers. It is done in the best interest of the patients. Unfortunately some private-sector partners choose to use different protocols which makes it difficult for patients when they are subsequently referred to the state facilities.

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Sheila Hokwana

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I think the MSF in Lusikisiki is a case that we can copy, because when MSF was about to leave, they informed us in good time to say, we will be leaving and therefore we will need the government to take over the programme or the project. And therefore there have been constant discussions and activities done so that the exit of MSF doesn't leave patients in the lurch, but patients are managed within the health-care system. I think that is one lesson that we can learn from the NGOs that are operating in our area, so that we communicate with them in good time, so that we know their activities and understand what would become of the patients when the NGO actually leaves.

”



Dr Eric Goemaere

“ My question is about universal access. You answered that, in fact, government perspective was more in terms of accreditation of the point of care at district level and you said, ‘and now we move to sub-district level and we might achieve 75% of sub-district level’. I wonder if we are not simply in a problem of terminology here, a semantic problem. ... Can you please tell us how do you define the feeder clinic concept, what does it mean and whether or not they will become accredited if their referral facility is accredited? ”



Dr David Kalombo

“ When we are talking about the districts and sub-districts it is in terms of the geographic consideration. The accreditation of facilities can be done to a single hospital, clinic or a service point. A facility can work alone or have the services spread among feeder clinics, e.g. the readiness of patients can be done at one clinic and the actual initiation of ART done at another. The feeder clinics can be used as a down-referral facility for stable patients if there are adequate human and financial resources. ”



Dr Hermann Reuter

“ My question is linked to Eric Goemaere’s question. Your answer was that in some sites the accreditation is linked to the budget; you don’t know how much to budget for. Is the accreditation process linked to budgets or is it linked to medical criteria? ”



Dr David Kalombo

“ The accreditation is based on the needs. The need will determine what budget will be allocated in order to achieve patients’ quality care. ”





Dr Lesley Pitt



The question I wanted to ask was around this issue of the multidisciplinary team and the inclusion of traditional healers, which I think is a very good idea. I think it goes a lot further than that. I just want to ask from a community perspective, what is going to happen to the caregivers in the community, the community health worker and so on? How are they going to be involved in the plan? Are they going to be funded through the government, are they going to be included in the supply of drugs to the community? How are they going to be used, along with your traditional healers?



Dr David Kalombo



There are structures in government that deal with care givers and community health-care workers, their support is essential in the implementation of the programmes. The supply of drugs will continue to be done by qualified professionals. Traditional healers are members of a multidisciplinary team and will continue to provide the support to patients in their communities.



Tandi Xozwa



Do we have a future plan, when you talk of human resources – like nurse-patient ratio, doctor-patient or pharmacist ratio – to address the gradually increasing workload of all the staff members, and then to prevent the burn-out? Because those people are still human beings and at the same time they need to be taken care of.



Dr David Kalombo



We now have an HR plan and are working on a workload study this year. And this plan and the study will address the issues.



Daniel Berman



The issue came up this morning about the fact that some foreign doctors get a job offer, not within an NGO, but directly with the Department of Health. They get a job offer and they're willing to work in local terms but it takes eight months, a year, sometimes never, or people give up; most people give up before they get there. And I'm wondering what your department is doing to change that? I know it's not your direct responsibility, but if you're responsible for implementing the plan and there's a huge lack of doctors and open posts, it seems like there might be some connection.



Dr David Kalombo



As in the last question, the HR plan will address the issues. The Health Professions' Council of South Africa is ultimately responsible for the registration of foreign doctors.





Dr Mosa Moshabela



We know very well that the plan, one of its goals is to strengthen the district health system. And you've mentioned that you've appointed co-ordinators in the facilities and at a provincial level. But when it comes to clinics, clinics do not work with the facilities, I'm talking hospitals now, and provincial co-ordinators will not be able to manage the districts. So are their plans also to appoint ART managers at a district level in the near future?



Nomalanga Makwedini



The current problem – I'm going to relate this to how we're dealing with this issue in the Eastern Cape – we find that most of our clinics do not have 100% staff, even hospitals for that matter. Most of them, they are 70% or 60% staffed, so, with such a situation, where we have a gross shortage of human resources, you are unable to say, your current staffing norms, are they meeting the demand or not? So that becomes a very critical issue because you don't want it to create posts. Let's say you have a clinic that is supposed to have five registered nurses, currently you've got two, why do you create two more, when you have not filled the other three? That is a big question that is coming from ORD. ... Unless we have already filled all the posts, then we're able to say, the nurses or the health workers cannot cope. So this has got to be looked at differently.

There are lots of non-nursing or non-clinical duties that are done by nurses. We should be having the data capturers to do data-capturing. We might be saying that they are over-worked because, currently, we're making them do work that should be done by another category of worker. If then we start filling up the posts of data capturers, clerks and all of those people, then we'll be able to alleviate most of the burden from the nurses. We need to employ pharmacy assistants to do their job of dispensing rather than having nurses running between examining a client and then again having to dispense the drugs. In the Eastern Cape, in the district, we have got what you might call ART managers. We don't call them that in our province, though we say treatment care and support manager, because we don't want to verticalise the programme, that you've got only a manager to manage ARVs. What about those who need just chronic care? They are still HIV-positive, but they need to be followed up; they are not yet at the stage to receive ARVs, but you want to constantly monitor those clients. Like it was mentioned, some of your clients can boost their nutritional status. Do anything, but those people need to be under your care, so we don't label those managers as ART managers.



Dr Marga Vintges



We are here together with quite *crème de la crème* people working in rural areas and they all have credits. Is there a question maybe that you have for us, something that we can help you with?



Dr David Kalombo



All I can say is that the department appreciates the efforts of every stakeholder. We have been saying that there is no way that we can manage this programme alone. So if anyone says we're failing, we're all failing. So it is not about people pointing fingers at each other, but it is about engaging with one another on issues which we can solve. And we appreciate the involvement, the participation of the stakeholders, and please talk to us. There were issues of us not being accessible. I think we are accessible to those who really want to talk us, as we are all grappling with the same issues.



Emerging Themes

MODEL OF CARE

DR ASHRAF GRIMWOOD

A Rural Model

The discussion has been quite difficult. We started off by trying to define where this model should be. And we decided it should really be rural – because this is the focus of this discussion – and not urban, peri-urban or informal, otherwise we'd be here for the whole day. And we finally agreed to a model for a hypothetical area, deep rural, requiring a mobile team of mentors, of a doctor, a couple of nurses, depending on the area, and lay counselling, who would be responsible for maybe five or six clinics.

Capacity

The whole idea would be to develop the capacity of the clinic, ensuring that the staff are able to continue with a very good quality service. Not to forget, though, that there will also be the development of community preparedness, community mobilisation, through the use of community care workers or community adherence workers, trained up to support

the clinic teams in adherence monitoring, follow up, reporting back on patients, and psycho-social assessments.

Training

And there was a suggestion to overcome some of the problems of the shortages. A clinical officer or a nurse who might be trained through distance learning, but with the focus being on mentorship, where they become clinical officers. But, then they are tied into a three-year contract plus with the province where they'll be working, to continue to provide that service. They don't have a haemorrhage of skilled staff as you've had with the PMTCT-trained nurses.

The course obviously will be accredited. Also, with community care workers, supported by the expanded public works programme, begin the creation of a career path for community workers who are trained up on adherence. There is a suggestion as to where these career paths could go, either to nursing, counselling or adherence support. The idea would be that the trained nurses would ultimately be initiating therapy as your officers.



MARIANNE KNUTH: Are there any questions from your group? Any questions that are still alive and unanswered?

Issues around sustainability, the training content and recruitment of community supporters. Who's going to be responsible for the orientation and the management of the mobile teams?

There needs to be some sort of conductor of this orchestra. And then again the issue around task-shifting, issues around testing; who'd do the testing?

ACCREDITATION AND POLICY

DR STANLEY MUWONGE

We've had a very hot discussion about accreditation and policy issues, you can imagine. I've summarised it as follows.

What we decided, or what we agreed on rather, is that there is a national policy that is clear, it is facilitatory and it is flexible. We agreed that implementation is a provincial

mandate and there are managerial issues that may present problems.

The way forward is that the national policy needs to be communicated clearly to all stakeholders and that will help hold both national and provincial accountable.

Now the hanging question is: how?



and Challenges

PARTNERSHIPS

DR MOSA MOSHABELA

After this talk I'm not going to be popular, especially from our friends in government; they'll excuse me. I'm going to sound very much like the TAC (Treatment Action Campaign).

We started off by asking the question: who are the partners? And there's a lot of partners, including all the non-governmental organisations, the non-profit organisations, the academic institutions, the people living with HIV and AIDS, and other community structures that exist in terms of providing health care.

Working with Government

We also agreed that government is the major stakeholder in health care in this country and that's a fact. And, therefore, especially when it comes to sustainability, we need to work in line with government.

Now the problem is, how do we get to work with government? We realise that in terms of working with government, we need to develop clear service level agreements, right from the start. If we're going to be partners, we both have to have an agreement and bring forth what we're able to provide and what the expectations are. And that's a major barrier to get through right from the start.

What normally people find is that when they deal with top-level officials, say national, things are easy. But the moment you go to provincial, things become very difficult. The moment you go to district, and even facility, it becomes even more difficult. And we also realise that it's very important to establish good re-

lationships on the ground but it just doesn't happen. If it does happen, it takes a very long time.



“A lot of government officials, especially on the ground, seem to be disempowered in terms of decision-making.”

Trust and Commitment

Some of the key things that we find are issues involving trust. A lot of times it doesn't exist; we don't know where this comes from, but that's what we find.

The second thing is commitment. We find that the issue of commitment is questioned, even after service level agreements have been signed. At times you find that it's only one partner who's committed to activities or to the agreement.

Another issue: it's the issue of leadership. We think that this will

be an answer to the issue of partnerships, but a lot of government officials, especially on the ground, seem to be disempowered in terms of decision-making. People keep taking you from pillar to post, time and again, over months and over years, without arriving at a final conclusion, or an answer, or a decision. And, as a result, programmes delay, patients wait for a long time and they die.

Now, a lot of other people have embarked on the grey area syndrome, whereby people just come in and start working without any agreements. This is not ideal, but it has worked for people and I'd like to find out from Médecins Sans Frontières (MSF) if they know anything about that? But at the end of the day, people might end up working and try to work on a proper model that after a couple of months or years they are able to present to government, to say, “Is this acceptable to you, can we now go on to some kind of agreement?” But the problem is, it takes a lot of effort, a lot of energy and some people on the way, they quit before they can even provide the service that they are supposed to provide.

Solutions?

Solutions we don't have. We've got a lot more questions and I think it goes back to the question of “how”? How do we get government to be much more open and willing to form partnerships?

And these issues that we've mentioned – commitment, leadership, trust, competence – are the things that we're asking for from government. Also, the model should be in context; the partnership should be context because you cannot use the same models for everyone.

HUMAN RESOURCES



LYNNE WILKINSON

We had the rather difficult topic of human resources. We discussed the obvious problems of getting people to work in the deep rural areas.

Environment

A large point that is often missed is that providing a nice team, a motivating environment for a new nurse, doctor, social worker or dietician, really adds to people wanting to stay in rural areas, even when the conditions are not optimal.

Infrastructure

From the perspective of actually trying to deal with the infrastructure problems, we identified that it's not so much... well it is the accommodation and the roads, but it's also the lack of supporting services that creates problems for people living in rural areas for a long time. For instance, the lack of availability of schools, or of churches of the specific religion that the person may belong to.

Solutions

We came up with a couple of potential solutions to these problems.

Incentives. The first was government potentially paying health professionals incentives to allow their children to go to good boarding schools. Because a lot of people move away from the deep rural areas once their children reach a school-going age. But if they were actually supplemented in providing schooling for their children, potentially this problem would go away.

Rental allowance. The second problem is obviously the accommodation problems, which we have both at the hospitals and at the clin-

ics. And we discussed the potential of government providing a rental allowance so that staff were not required to live in the hospital in order to qualify for free accommodation. ... The community could potentially build accommodation, which could then be rented, providing a benefit to the health-care worker, as well as the community.

Grade rural pay. The third idea that we had, which we've spoken about before, is potentially grading the rural allowance so that people benefit more from a deep rural setting and people who live in a semi-urban area are not getting the same rural allowance.

Use clinic committees. The last issue that we spoke about specifically was, for instance, the conditions at the clinics: the access roads, the lack of electricity, the lack of water. And we were saying that one of the solutions there is to make use of the clinic committees, which most of our clinics have. And try and motivate them to demand improvement of services at their clinics in order that they are able to recruit and retain staff.

They have a lot more power than we often believe they do and if we assist them and support them in lobbying for that improvement, potentially it would happen.

Prevent urban migration. There were a few other issues we discussed. One of them was also our problem of giving people higher-level posts and then the problem that results when they then move to an urban area keeping the high-level post.

And we suggested that if people are offered a higher-level post, and this relates to all health-care professionals, including doctors, social workers, dieticians and nurses, then they are tied into a fixed-term contract.

So if you get a higher-level post, when you qualify for a lower-level one, that you are either obliged to work for three or five years in that setting.

On-site training. The other point that we identified as a problem was that staff are often removed from the facility at all times for various sets of training, often leaving the facility with very few staff at any one time. And, really, trying to focus on creating practical training at the sites and for the provinces to come up with some ideas about a team, essentially of mentors or teachers, that come and actually teach at the site with the team. It will also allow more practical training and less theory.

Issues Outstanding

And we had a whole lot of further issues which we didn't get to. One of those was our problem of working with the HR admin function within government, which often causes a vast delay in employment of staff. The other issue which we didn't tackle was our need for further counsellors behind the community and the appropriate way to fund such a system.



TO THE POINT: Nomalanga Makwedini, from the Eastern Cape Department of Health, discussing the human resources issue.

TASK-SHIFTING

Task Identification

DR HELEN SCHNEIDER: We looked, first of all, at the life course of illness and identified points along that life course. From, you know, the point of voluntary counselling and testing, case finding for opportunistic infections, diagnosis, initiation of treatment, maintenance, etc. We identified, right along that spectrum, a whole lot of tasks that can be shifted from professional workers to patients, from professional workers to lay workers, from doctors to nurses, pharmacists to pharmacy assistants. There's a whole spectrum and quite a few of them have already been covered.

Structure

Then we looked at the structure of the health service and all the people in it and looked at it from a structural point of view. What you could send down the line, as it were, what you could shift.

The underlying conclusion is that a huge amount of task-shifting is possible if you've got a coherent system with all the different elements in place and, in particular, to have the connections between them. So that you've got, for example, a good relationship between a district hospital and a district management team and clinics, then you can do a huge amount of task-shifting. If you've got, for example, well-functioning regional training centres at a regional level, then you can train all these people coherently at a local and district level.

Categorising Staff

DR EBRAHIM VARIAVA: I think one of the issues we looked at as well, was at a clinic level what sort of staff you've got, and we tried to categorise your staff.

We know that some clinics have primary care-trained nurses, professional nurses, enrolled nurses and enrolled nurse assistants (ENAs), each with specific functions. All clinics don't have that level of staff, but also related or linked to the clinics, you've got a whole host of other NGOs working for the Department of Health. The home-based care groupings that have been sponsored by the Department of Health, are functioning fairly independently.

We are looking at these cadres of health-care workers and trying to focus on what they should be doing. The DOT supporters, for instance, should not only just function on DOT support; it's basically taking in the TB programme and trying to co-ordinate it. They should also be assisting with VCT and adherence counselling. Your support groups should be linked to the various home-based care groupings.

We looked at all the other issues related to the entire programme and, I think, it will be better clarified when we try to add much more meat on to the flow diagram we came up with at some point.

Task Inventory

DR HELEN SCHNEIDER: What we thought is needed is a full inventory of all the tasks that can be shifted and then to say, well what specifically is the organisational or institutional impediment to changing that? Where's the decision being made around that? And we need to find that out as the next step before we can make proposals for shifting tasks.

Context

MARTA DARDER: Basically, we didn't have enough time. It's not enough time if you are looking at all the tasks that can be shifted and what are the players and it's so context-based at the moment.

The solutions are being invented by people who are struggling with the issues on the ground and they come out with whatever possibilities they can.

Basically we've been learning from each other about how we found different solutions to the same problems by "doing", and based on wherever we were.

But as for the principal role of this group, which was to actually make some kind of tentative terms of reference for the different groups or different layers, we didn't get there.



Dr Helen Schneider



Dr Mothomang Diaho



I get a sense that a lot of issues were raised today. And some of them we started grappling with, for instance the five issues that were raised. But I think in my reflection tonight, I'd like to come back tomorrow so that when we pass this document around, the recommendations that we made are very specific in certain areas. I think listening to the presentations, there are certain areas where I got a sense that within the next year or two certain things can definitely be done. And I think tomorrow I would like to see that stated clearly: what can be done. And then also state in another section what we propose is something that needs to be looked at as parallel to what it is that we are proposing, so that it's a much tighter recommendation for policy-makers, ourselves and other partners. I think it needs to come out very clearly.



From Ideas to Action

Strategies and recommendations for HIV and AIDS care in resource-limited settings

GROUP OUTPUT

Models of HIV Care

Group Representative: Roeleen Booï

Introduction

These models of care employ a decentralised approach to the provision of comprehensive HIV care and treatment services.

They include:

1. A mobile multidisciplinary team that is stationed at the accredited hospital and travels on a regular basis to the primary health clinic (PHC) to initiate patients on ART.
2. A multidisciplinary team available at the PHC level to initiate ART.
3. A multidisciplinary team at the accredited hospital to initiate ART and down-refer patients to a PHC to continue treatment.

One or a combination of these three models is operational at each ART accredited service point (consisting of a hospital and feeder clinics).

Criteria For Success

For the decentralisation to be successful the following are needed:

1. Clear protocols for HIV management should be available at PHCs.

Some of the important areas that the protocols should address are:

- When to initiate ART.
- When to refer patients on ART for further management.

- How to recognise and manage side-effects and adverse drug reactions.

Identified resources include:

- www.msf.org
- Pulsa+ (proposed for Free State)

2. Mentorship of doctors, nurses and lay health counsellors is needed to improve HIV management skills at PHC level.

The main gap identified in the successful implementation of the above models of HIV care was nursing mentorship or preceptorship.

- An HIV clinical preceptorship training programme for registered nurses needs to be established. The end product of this preceptorship programme is registered nurses with skills needed to mentor other less experienced nurses at PHC level in HIV management, including ART.
- A job description or scope of work will need to be developed.
- Resources identified for this task include NGOs, nursing colleges/universities, regional training centres and the skills development unit of HR in the DoH.
- Policy issues regarding these newly skilled nurses will therefore need to be urgently addressed. Some of the issues that will need further deliberation are: remunerating the nurses graduating from the preceptorship programme, official recognition of the existence of this new cadre of



staff and, in the long term, budgeting for this position at PHC level.

3. Additional auxiliary staff at PHC – “Task-Shifting”

- Lay health counsellors are needed to conduct pre- and post-test HIV counselling; including performing the actual rapid HIV test and for clerical duties.
- Data capturers – required for data collecting and assisting in compiling reports on HIV indicators.



DECENTRALISED DELIVERY: New models of care need to be developed.

GROUP OUTPUT

Steps Towards Getting Your Facility Accredited

Group Representative: Dr Ebrahim Variava



dispense on site or a pharmacist assistant supported by a district pharmacist.

1. Space

You need:

- A consulting room and a counselling room.
- A waste management system (boxes for needles and red plastic bags for medical waste) and the company used by the district to collect the waste.
- A cellphone or landline for patient communication.

2. Basic HIV and AIDS Services

You need to deliver or have easy access to the following services:

- Family planning.
- Antenatal services.
- VCT.
- IMCI/EPI.
- PMTCT.
- TB management.
- STI.
- PEP (can refer to nearest service provider).
- Nutritional support (can be done by the district).
- Social worker (can be done by the district).

3. Policies and National Treatment Guidelines

You need to be in possession of these guidelines:

- Written confidentiality policy.
- Written universal infection precaution policies.
- National ARV treatment guidelines (blue book for children, orange book for adult, green book for management of side effects).
- Contraceptive guidelines.
- Antenatal guidelines.
- VCT guidelines.
- PMTCT guidelines.
- TB management guidelines.
- STI guidelines.
- PEP guidelines.
- Nutritional guidelines.

If you don't have these, they are freely available at your district office or referral hospital.

4. Laboratory Capacity

You need:

- Someone trained to draw blood.
- A protocol to store and transport specimens.
- Access to CD4 testing.

5. Pharmacy Capacity:

You need:

- A clinical nurse practitioner or a professional nurse licensed to

6. HIV & AIDS Service Point

You need:

- Access to care, treatment and support.
- A 24-hour service, if not a referral system (hospital), for nursing care and doctor care.
- Access to expert consultation.
- An identified hospital you can refer patients to.
- Appropriate trained staff managing HIV and AIDS at the service point.

7. Staff

You need the following staff. If you don't have them, you have to have a plan to recruit them and a plan to train them for HIV and AIDS:

- Professional nurse.
- Staff nurse.
- Enrolled nurse.
- Dietician/nutritionist.
- Pharmacist assistant.
- Social worker.
- Lay counsellor.
- Admin clerk.
- Data capturer.



Dr Ebrahim Variava

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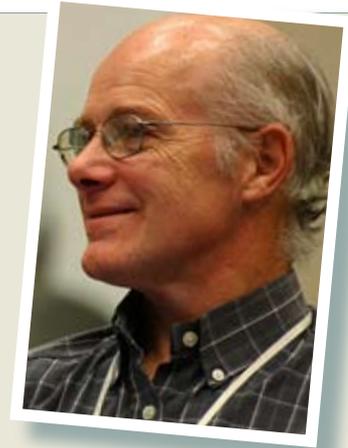
I think it's actually very easy to get accreditation going. Almost all clinics probably can prepare for accreditation quite quickly and quite easily and I would suggest that they go through this list, see what they have and then submit it through the provinces and see if they can get accredited. It's probably a worthwhile exercise to do.

”

GROUP OUTPUT

Integration Into Chronic Care PHC Model

Group Representative: Dr Victor Fredlund



Introduction

Integrating ARV medicine into the primary health-care model of continuing care is a logical step. Patients have many similar requirements to other chronic care patients. The clinic setup should have all the elements required and the flow of patients through the different elements should be directed and monitored by a triage nurse. This could be an enrolled nurse.

Elements Needed

- Triage nurse
- Records
- Counsellors
- Procedures room
- Nurse clinician
- Doctor clinician
- Dispensing
- Social worker
- Dietician
- Data capturer

The role of the staff nurse (or staff nurse team, depending on numbers) triage is crucial. All patients are given the

cough screening and then appropriate tests – blood pressure or blood sugar, previous lab results and institutionally held files to be obtained, etc.

Those just needing medicines are then fast-tracked to counselling and then dispensing, if on ARVs. At specified review periods or with complications, patients to go via counselling to clinician (either a nurse or doctor according to programme).

Visits to other segments are arranged periodically or if the need arises. TB patients could well benefit from adherence counselling and dietary advice, as may hypertensives!

We need to import some of the ARV programme models into other chronic care programmes.

Other considerations:

- **Vary the rooms that are used?** This may help so that stigma does not get attached to entering certain rooms.
- **Adherence training could be extended to TB patients.** Same counsellors. Additional skills can be

added but we should be careful not to swamp activities.

- **Patient record** is an interesting issue. Patient-held is good but needs organisation. For example, one A4 page fitted into pocket with tabulated drugs on one side and results on back.

Analysis of data should be done as survey sampling rather than blanket collections?

Three Points to Take Forward

- Engaging HAST nurses for triaging.
- Training counsellors on issues of adherence in TB, hypertension and diabetes.
- Looking at patient records that give rapid overview.



Dr Eula Mothibi

“ There is that move to try and multi-skill these counsellors, so that they’re doing everything. When they go into the home, they don’t just say “No I’m HIV, I’m coming to check your tablets”. The one person is able to do diabetic testing and talk about hypertension adherence. So there is that recognition from national DoH, granted, that these people need to be multi-skilled in those ways and there is a module, which probably hasn’t been rectified, on how to train them. But I think all those things will be coming; people are thinking about those issues. ”



Dr Hermann Reuter

“ I think one needs to think about the danger of then giving them everything to do and I don’t think that’s what task-shifting means. Task-shifting means identifying a very specific job that somebody can do. Obviously if that person, at some stage, acquires the knowledge to do more than the HIV work, then they can also be trained to do diabetic work and to do hypertension work and so on. But I think the initial shift is towards a very specific job description. But, obviously, as that person visits the house, they will hear about other illnesses and come back with more questions and then we should train them more comprehensively. ”



Dr Doris Macharia

“

I was in this group. It's not only the counsellors and I think Victor's mentioned that. It's just looking at the flow of patients and seeing what you have. Even if it's a staff nurse or an enrolled nurse assistant (ENA), you know, what more can they do? So that it's not like: "Oh, I'm only here for the HIV thing," you know?

”



Dr Marga Vintges

“

I'm very interested in your ideas about the file, the record-keeping system ... We have already developed a special file and a special patient booklet for HIV patients. A file with, you know, the lab results and everything that you use at your ARV site. Now I'm thinking, is this the right way? Should we have a general file system in which you can also monitor diabetes and hypertension? It taps into this whole idea about vertical and horizontal, of course. Should we wait for an integrated file to be developed or should we not start with ARV being a bit vertical, because it's a new thing for everybody? Once you get established, and you get used to everything, and you know you're comfortable with ARV in your clinic, then go for the integration?

”



Dr Victor Fredlund

“

I think the flow sheet is an addition to a patient-held record system. In our experience in Mseleni, we actually developed a patient-held record that looks the same for everyone but is capable of containing the information for ARVs as it can contain the information for hypertensive medicines and for anything else. So it has a results page, it has a treatment page and then it gives you the same thing. But the motivation to make that happen came partly because of the ARV programme. Which meant that all the patients got it, not only 10% that are on ARVs, or 2% that are on ARVs. You can't see from outside which patient it is, you see, it's the same book for everyone, which may be an advantage.

”



GROUP OUTPUT

Involving General Practitioners in HIV Clinical Management

Group Representative: Pumla Kobus

Introduction

There are approximately 10 000 GPs in private practice in South Africa and of those over 6 000 are trained in HIV clinical management.

Through these GPs, there is a potential to demonstrate and develop the capacity of the private sector to provide the much needed human resource and infrastructural support for comprehensive care delivery for people living with and exposed to HIV and AIDS.

The aim is to align the distribution of medical practitioners, of whom approximately 70% are in the private sector, to the distribution of patients, where only 16% of the South African public have medical insurance, with a significant number of them not fully covered for access to ARVs for a full calendar year.

These doctors are available as an immediate medical resource in the clinical management of HIV and are in areas where patients are located, providing easy access to care, privacy and confidentiality.

The following are lessons learned from the Tshepang Trust (an NMF-funded project).

Two Approaches to Involve GPs

1. Sessional

GPs involved on a sessional basis in public-sector facilities, i.e. hospitals, clinics and health-care centres within the communities where potential patients are, in order to alleviate the burden of treatment at public ARV sites and reduce waiting periods for patients before they can be seen by practitioners.

2. Private GP Model

This is a model where GPs are seeing

public-sector dependant patients from their rooms at no cost to the patient.

This would help to address:

- The infrastructural problems faced by public-sector medical facilities.
- The issue of stigma, because patients would be seen in a private setting that promotes privacy, confidentiality and individualised quality of care.

Logistics

Logistics for offering medical treatment at GP rooms are around laboratory testing and drug delivery.

- For laboratory testing, the National Pathology Group (a partnership of private laboratories) is in partnership with the Tshepang Trust and doctors send lab tests through these laboratories and the trust manages the costs.
- For patient access to drugs, drugs are delivered patient-ready to the GP's rooms and patients collect their medication from there.

Monitoring and Evaluation

Tshepang provides a monitoring and evaluation programme that is responsible for:

- Patient registration and referral to doctors.
- Recording of patient clinical information.
- Reviewing of scripts and monitoring of patients on treatment.
- Reporting.
- Adherence monitoring through



patient managers and counsellors on the ground, working in conjunction with the doctors.

Project Management

The Tshepang Trust provides project management of the GPs, offering services on a sessional basis. For example, drawing up rosters for doctors, providing registers where they sign in for hours worked, remuneration, etc. The trust also provides a comprehensive disease management programme through its patient managers.

Additional Inputs

The group had these additional inputs:

- There was concern that all public patients might want to go to GPs and hence overload the system. A possible solution to this potential challenge would be charging a small fee to patients wanting to go to GPs instead of the public ARV sites.
- For sustainability, everybody agrees that the government needs to assume ultimate responsibility for maintaining initiatives aimed at assisting with the HIV epidemic. To this effect, policy issues surrounding the national treasury agreeing to state drugs being delivered to doctors' rooms needs to be researched.

GROUP OUTPUT

Expansion of ART for Children in Deep Rural Areas

Group Representative: Tandi Xozwa



1. Incorporate other recommendations by paediatric discussion groups

- Review guidelines to increase family care at primary health-care level.
- Have a proactive outreach for paediatric support.
- Simplify paediatric treatment to look at weight bands.
- Promote simplification of doses – move to tablets early.

2. Increase recruitment for testing and treatment

- Availability of promotion materials posters to educate at primary health clinics.
- Education at immunisation clinics, antenatal care clinics, and pension points for grandparent caregivers.
- Do not only educate at high schools but also at primary schools.
- Accelerate dry blood spot use (PCR) by antenatal care (ANC) nurses.
- On-site training while waiting for formal training, including Integrated

Management of Childhood Illnesses (IMCI).

- Education within adult support groups to test their babies/children.
- Co-stickers system on files (PMTCT mothers and HIV-positive adults) for following up on tested children.
- To include relevant information on Road to Health Card as a part for screening.



Dr Victor Fredlund



Did you think about the inclusion on the Road to Health Card of the PCR result, as a standard block? Because, I think, a lot of things that happen on the Road to Health Card are good. If we had a PCR result six weeks under the immunisations, immediately we'll be jogged to test.



Dr Bernhard Gaede



I think maybe to even extend that ... to have the mother's HIV result, from antenatal, on the Road to Health Card. Because they've done six weeks. That means that the PCR gets done. I think that's what is really the big gap, and that ABC, secret code, Second World War system, just doesn't work.



GROUP OUTPUT

Engaging Volunteers/ Community Workers

Group Representative: Dr Mothomang Diaho



Introduction

The magnitude of the epidemic calls for unity of purpose and demands that we work together and reach beyond the facilities to engage communities. Community-based volunteers are the interface between the community and the health facility. Successful and innovative programmes have engaged community-based volunteers as demonstrated by the MSF adherence counsellors (HAACO).

Guiding Principles

There has been an explosion of these community-based support groups over time. It is imperative that we have clear guiding principles in working with them. There is a lot of duplication of their functions on the ground as a result. The group shared some of their experiences and observations in working with volunteers.

- Members of support groups must come from the community.
- They must be sensitive to local community experiences and have a willingness to work with existing community-based organisations.
- Community members also join these groups in the hope that they will get jobs.
- In rural communities, though, there are very few choices in “job” selection.
- Participation by volunteers, if done well, such as decision-making in clinic communities, empowers individuals.

- Support groups’ enthusiasm has rubbed off on nursing staff in some clinics and added positively to staff morale.
- It is easier to engage existing volunteer groups in the community or create new support groups through the clinic if none exist.
- Being involved with a support group gives one status in the community.

Incentives

- Government and NGOs have now provided some stipends to the volunteer groups.
- Some have opened their own bank accounts as a result.
- The MSF adherence counsellors get a stipend paid at the government scale.
- Should consider planning their careers within this context.
- Identify leaders/champions in the group and provide further support to them.
- Include PLWHA in the groups.
- We should consider other non-financial incentives.

Training and Accreditation

- Develop a clear strategy to develop volunteer capacity.
- Ideally, if training is involved, it needs to be carried out in the community.
- Training must focus on basic issues of HIV and AIDS treatment literacy, treatment preparedness, adherence,

community-based nutrition, etc.

- We need to promote wellness as part of the training,
- Support groups should meet during clinic time to provide assistance to both patients and clinic staff.
- Training should be a combination of in-house and training subcontracted out to accredited institutions or individuals.
- Need to provide counselling and debriefing sessions with support groups, at least twice a year.
- Provide recognition for excelling members.
- Consider innovative ways of sustaining motivated members.
- Consider members of support groups being considered for higher positions when task shifting.
- Build in a mentoring system to support the groups.
- Set up a monitoring and evaluation system for support groups.
- The innovation that has emerged from HIV support groups needs to be shared with other programmes such as the TB programme.

Conclusion

No one individual, organisation or government can respond to the epidemic in its entirety. The epidemic is evolving and demands that we constantly look at our approaches and act accordingly.



Dr Mothomang Diaho



In the areas that we work, we’re going to engage some of these recommendations. A lot of people work with volunteers and community workers where they come from.



GROUP OUTPUT

Community Involvement in ART

Group Representative: Dr Hermann Reuter



Who is the Community?

Initially, the discussion revolved around “who is the community” and that the way the community is defined often influences how the local population is being engaged. The total population constitutes the community; however, only a small number of people are active in the participation in projects.

Formal Structures

Traditionally, the standard approach has been to approach the “official” bodies and stakeholders of the community – the traditional leaders, municipal councillors, church leaders, leaders of organisations or the members of hospital boards or clinic committees. In practice, this approach yields little in the way of real change in the community and few people on the ground get involved or get information regarding what is going on.

The “formal democratic” structures have limited impact on involvement in actual change in the community and there is often a veneer of participation

and real decision-making.

Support Groups Work

From a number of examples that were shared, the involvement of support groups seemed to have greater impact.

The groups were used for the dissemination of information regarding the disease process as well as the service delivery. In a number of examples that were shared, this led to a demand for better service from the health-care services – including a demand for ARVs at the clinic or hospital and demand for improved treatment for opportunistic infections (such as herpes).

The support groups continued to share the information with new patients and play an important role in motivation and monitoring adherence. The process results in the “users” or “clients” of the

service demanding service and thereby having a greater say in the improvement of the service.

“The support groups therefore started to be transformational in a wider context.”

As the support groups become more established, in one example that was shared, the support groups started to be more involved in the existing community structures, such as the Nkosis’ Councils, to address a number of issues related to domestic violence

and rape. The support groups therefore started to be transformational in a wider context than the group itself and have greater standing and stature in the community. The process of community mobilisation therefore has a greater impact than a more passive process of sharing information within the formal structures.

Recommendations

- Community mobilisation, especially of HIV-positive people in their fight for health.
- Health promotion budgets from the Department of Health to be used to support local support groups in their organisation and community mobilisation.
- The health promotion process to be a “bottom-up” process (communities telling the Department of Health what their demands for service are) rather than a passive top-down approach. This is in line with the WHO Ottawa Declaration on Health Promotion.



STRENGTH IN NUMBERS: Community workers are integral in the fight against HIV and AIDS.

GROUP OUTPUT

Support Groups: Adherence and Maintenance

Group Representatives: Nondumiso Ntsikeni and Akona Ntsaluba



Challenges

- No space or accommodation for support group meetings.
- No food for support group meetings. We are forced to meet for a very short period of time before people get hungry.
- We do not have transport for outreach to the outskirts of the municipalities, even if we are invited to funerals for destigmatisation.
- Lack of recognition by government departments, especially the Department of Health. Integration

with primary health services is not there.

- We are not part of decision-making committees for our voices to be heard.
- Stigma attached to HIV-positive people within government departments makes task-shifting difficult.
- Even if we are registered as an NPO, we are not given a chance to do catering for HIV and AIDS campaigns. The funding can be a source of in-

come for our projects, for us to continue with ongoing counselling and visiting the needy.

Solutions

- Department of Health and the municipalities must see to it that support groups have space in all the ARV sites.
- Department of Health must take a leading role in all clinics in Lusikisiki and Qumbu Health Centre and other support groups.
- Workshops and capacity-building by the departments.
- Transport dedicated to support groups to help where there is an outreach (e.g. campaigns).
- Support group members to be employed in each and every department and to be offered incentives.
- Incentives should be offered for lay counsellors from support groups, who increase VCT and ARV uptake.
- Support groups to be funded by the Department of Health.
- Call for proposals must be distributed to all the support groups.
- All AIDS forums to have a support group representative so that local HIV and AIDS issues can be addressed.



Dr Hermann Reuter

“ I think there’s very much a revitalisation of primary health care going on and I think it’s important to include in that floor plan of those clinics, space for support groups.

”

GROUP OUTPUT

Empowering Health Workers in Rural Areas to Reach More Clients

Group Representative: Sheila Hokwana



Training

- Training of all health workers in primary health care in all aspects of HIV and AIDS care and management, so that clients are not referred to certain specialist nurses and doctors, but are able to access care in all health facilities.
- Rotation of health workers, so that all health workers are able to put their training into practice in all areas of health care and not just be confined to one area.
- Training of professional nurses to initiate treatment.
- Availability of protocols and manuals in all facilities.
- Mentorship.

Task-Shifting

- Employment of lower categories of health workers (staff nurses, nursing assistants, administration

officers, data capturers and community health workers) to allow task-shifting.

- Proper delegation of duties and time allocation.
- Partnerships can assist to reduce the workload, and sharing responsibilities can increase output.

Community Support

- Use of local people as treatment supporters and these must be attached to NGOs and local clinics for proper utilisation and monitoring.
- Use of support groups at local level to channel patients to available health services. Support groups are also helpful in monitoring adherence to treatment.

Policy-Making

- A change of national policies. For example, reopening nursing colleges.

- Allow a bottom-up approach to influence policy change. So that the health workers who are at ground level play a part in shaping the health-care system.

Other

- Speed up accreditation of rural facilities.
- HIV and AIDS must be part of a one-stop, supermarket approach.
- Mobile clinics and NGOs must be supported.



GROUP OUTPUT

Counsellors to Do “Pricking”

Group Representative: Bavuyise Vimbani

Introduction

Pricking is part of comprehensive HIV care:

1. Diagnose HIV.
2. Entry point to PMTCT, HIV care and ARVs.
3. Preventative strategy.

Challenges

1. Shortage of professional nurses to do pricking.
2. Some people are not tested because testing is restricted to nurses.
3. A high workload on the nurses. Counselling is done by counsellors but there is no-one to test, so testing should be shifted to counsellors.

Possible Solution

- Allow counsellors to do pricking because they are trained to do it.
- A nurse will draw blood for an ELISA test if the results are discordant.
- This model has been tested in Lusikisiki and other sites with good outcomes.
- The quality is ensured by doing screening and confirmatory tests, and working under a professional nurse.

Supporting Reasons

- Pricking is included in the VCT training curriculum.
- Pricking will build trust between the client and a counsellor.
- Pricking is safe because a vein is not



involved in the process.

- As a matter of interest, patients with diabetes prick themselves, but are not trained.
- More people can be reached for VCT.
- Nurses can have more time to assess patients for medical problems.

Conclusion

It is safe and effective to allow counsellors to perform VCT, including testing.



Sheila Hokwana



Ok, I just want to maybe correct something. I think it's a misconception of some regarding pricking and policy. The issue that pricking cannot be done by any other person rather than a professional, is not a provincial policy but a national policy. So if other provinces are doing it, they are doing it because they have found a way around the policy, but there has been no leniency in that policy as far as I know. So if we need to change that, we have to target a national policy.



Dr Marga Vintges



I don't understand why you don't work out of the box and let patients prick themselves. Then you aren't bothered by rules and regulations. Why not? It's easy; you are not disobeying the law.



Dr Mosa Moshabela



Initially, nurses were supposed to do everything, but counsellors were brought in to alleviate the stresses on the nurses. Then, nurses had to do the pricking so that they could be able to supervise counsellors and because they were doing everything under pressure. But the plan was also for these people, over time, as the counsellors get used to doing this, just basically to supervise them and see they can do it and to be sure. And over time the plan is for them to take it over. That's how it's supposed to be and that's the paradigm shift we should actually follow.



GROUP OUTPUT

Nurses Prescribing ARVs

Group Representative: Marta Darder



Introduction

Participants in the meeting acknowledged confusion created by mixed messages around the issue of whether nurses are entitled to prescribe ARVs or not. This would limit their ability to initiate patients on ARV and perform the routine follow-ups. The consequences of this confusion in rural sites is dramatic given the nearly exclusive availability of nurses in the rural primary health-care services. This group tried to clarify the legal, regulatory and political framework that may affect this question.

Conclusions

1. ARVs are Schedule 4 drugs, but government requires them to be handled as Schedule 5 in terms of storage conditions.

ARVs are Schedule 4 drugs (1), similar to other antivirals and to antibiotics. Nevertheless, government requires more management control over them and requests sites to handle them as Schedule 5 drugs (2). According to Section 30 of the Regulations of the Medicines and Related Substances Act (3), registers must be kept for Schedule 5 drugs, which must be stored separately, usually under lock-and-key to restrict access. Therefore, “handling conditions” do not refer to what health professional should prescribe or dispense, but only to control over stock management.

In addition, Regulations of the Medicines Act can only be applied to substances that are actually listed in the Schedule. Any arrangement to store and account for ARVs as if they were Schedule 5 medicines is therefore an internal decision of the DoH only, and has no legal bearing on who may prescribe or dispense such medicines.

2. Professional nurses usually prescribe Schedule 4 drugs.

The existing Section 38A of the Nursing Act does not specify a Schedule limit that nurses can prescribe (4). Nevertheless, the format of the permit makes mention of various “protocols”, which include only up to Schedule 4 medicines. In resource-constrained settings Schedule 5 drugs have also been included, particularly with psychiatric services. In addition, Section 38 of the Nursing Act confers capacities to the South African Nursing Council (SANC) to review the list of drugs that nurses can prescribe.

At the moment, the Nursing Act is under review as it is in conflict with the Medicines Act, thus there is no legal answer to this issue, which should be followed up with the SANC and the South African Pharmacy Council.

3. The South African National Treatment Guidelines do not include any restriction for nurses prescribing ARVs.

The National Treatment Guidelines state that treatment initiation should be done by a multidisciplinary team. It doesn't specify either that it has to be a doctor, or the composition of the team.

4. Nurses working in the public sector are allowed to dispense ARVs.

Dispensing regulations are common to all drugs and not specific to ARV medication. According to the current dispensing regulations (5), only practitioners (nurses and doctors) licensed by the Director General are allowed to dispense drugs.

The DG issues a licence upon an applicant's completion of certain requirements, including accredited training. A circular from the Director General issued just before the regulations were enforced in June 2005 exempted nurses working in the public sector from having to undertake such training and allowed them to continue dispensing to avoid the collapse of the public services that enforcement of such a requirement would

have immediately provoked.

5. The decision of whether a nurse can start patients on ARVs or not should be a clinical one dependent on the nurse's training and experience.

In rural settings, where doctors are not available, nurses should be able to initiate patients on ART. Nevertheless, it would be clinically advisable if severely ill patients or patients that are very immuno-compromised are initiated by a doctor. The ARV site manager or medical officer should decide on this. Once Section 56 of the Nursing Act is promulgated, nurses' competence can be recognised by registration in a specific category.

Acknowledgements

Thanks to Prof Andy Gray (Nelson Mandela School of Medicine, UKZN) for comments on this report.

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GROUP OUTPUT

Proactive Testing

Group Representative: Dr Victor Fredlund



Introduction

We developed ideas for getting well people to test and getting professionals into a treatment programme.

Motivation

- You need a motivation to test; an event that precipitates testing. Hence, many only test once they are sick.
- Tested at blood donation, marriage preparation, insurance, visa, etc.
- We need to emphasise the positives of testing to people.
- For professionals, we need to say

we are offering this to workers and advertise it to all government departments.

- Lack of confidentiality is a hindrance.
- Department of Education, Free State, has outsourced, but few come.
- Use private practitioners?

Precipitating Events for Testing

- Put testing into employment and job applications. This would be placing the issue before staff each time they promote or move employment.
- They would be asked to provide evidence that they had been for counselling but not that they had had a blood test or the results of it. This would mean that it could not be used as a discriminatory test.
- Churches should propose that people who are going to marry must test.
- Testing tents to be set up at paypoints for child care. Other ideas would be a mobile unit trav-

elling around schools. An example motto: "Good Teachers Test!"

- Set a date in the calendar to be known as a Testing Day.
- Encourage development of role models who test.
- Precircumcision testing.

Way Forward

The three main points that need to be taken forward are:

- Get all staff associations to promote the logic of "knowing one's status and getting necessary management and treatment".
- Discuss with public service the concept of a testing requirement at employment.
- Look for creative models for workplace and community event testing opportunities.



PATIENCE: Lining up at a clinic in Lusikisiki.



Dr Lesley Pitt



The only other one that I thought of was the use of GPs for teachers so ... they wouldn't have to go through the usual channels at clinics and be exposed to long queues and loss of confidentiality and that sort of thing.



Dr Hermann Reuter



For many women, getting pregnant is a stimulus to get tested. All the men in Lusikisiki, before they get circumcised, get a pre-circumcision medical check-up. If that could include an HIV test, it would get a large number of men tested.



GROUP OUTPUT

A Dialogue on African Traditional Practices

Group Representative: Dr Mosa Moshabela



Introduction

This dialogue was initially intended for a discussion around African traditional medicines in the face of antiretroviral treatment, but ended up including healers and cultural beliefs by default, due to the inseparable nature of these issues.

The dialogue table included two medical practitioners currently actively working with traditional healers, and one who conducted research on traditional healers. The other three members have an interest in traditional practices. The debate was a little biased in that it comprised members who largely regard traditional practice positively (mainly because it's here to stay, common in rural areas and a lot of people utilise it), and lacked strong opposing views.

Background

There is a clear division between traditional and Western health-care systems. The traditional system has its own weaknesses (toxicity, drug interactions), as does the western system, perhaps to a lesser extent).

Both groups have positive aspects attached to them, and it is believed that they can potentially learn from each other. It is clear that the two systems impact on each other negatively and maybe positively under certain circumstances. Often, it is a situation where you are working with someone in absentia, and you cannot hold them accountable or negotiate with them in any way. Both groups have one goal and purpose in mind, to provide health services to the same society.

Partnerships

Having said that, we realise that the notion of “together we stand and divided we fall” comes into play. The national TB programme has set a very good prece-

dent, by showing that traditional healers can be put to good use in health issues requiring a massive national response like HIV and AIDS in South Africa.

Dialogue Required

We all agreed that there is a need for a dialogue with traditional healers. The questions are: Can we involve them? Do they want to be involved? How do we involve them? At what scale do we involve them? What do we hope to achieve? Is this type of dialogue sustainable?

Traditional healers have a massive power of influence. The national government is working on formalising the traditional health-care system. With these two facts in mind, it sounds reasonable to initiate the dialogue.

We also know that most of the questions and concerns we have will not be addressed until we get on with the dialogue. Those who have worked with traditional healers believe that they want to be recognised and involved, but not to be ridiculed and robbed of their African science.

Sensitivity

The answer to the question of “how” remains with someone interested and neutral. This is a sensitive matter that needs to be approached with absolute care. We believe it can be done, and a breakthrough can lead to answers to many questions we have. It will bring an understanding that will take our nation forward democratically. The programme can have two-way information-sharing sessions, educational activities, practical sessions, and so forth.

We can define the different types of relationships that can exist between the two systems. We can request traditional healers to take an active role in the fight against HIV and other conditions. They can play a major role in community

mobilisation for testing and treatment, counselling, advocacy, committees, etc.

Principles

First, we need to learn to recognise and embrace them, and then listen and understand them. They will withhold their contributions if they sense any untoward attitudes. We need to stop being so prescriptive, and our negative attitudes will not help us at all. Good relationships and partnerships are built on trust, mutualism and positive regard. We have to be open-minded and receptive, and this can be achieved by conquering our fear of the unknown.

For a long time we dismissed the African traditional medicines while we knew little about them and their illness-explanation models, but this approach has to stop. We have created a barrier, and now we have the responsibility to break it down. As the government is working on a top-down approach, we have to initiate a consultative, bottom-up approach, and the two will eventually merge.

I cannot help but share what Dr Bernhard Gaede had to say to a group of traditional healers he was addressing in attempting to explain the problem of drug interactions. He asked them how they would feel if a patient combined different traditional medicines from different healers and took them at the same time, and they all expressed strong disapproval. And that's all it took for them to appreciate why antiretroviral treatment cannot be combined with traditional medicines.

Likewise, it will be important to address certain socio-cultural practices that may be fuelling the epidemic, with the traditional healers, community leaders and the community at large.

GROUP OUTPUT

The Dialogue Process and the NMF

Group Representative: Helen Struthers

Introduction

Mothomang Diaho from the Nelson Mandela Foundation gave a brief background to this discussion.

She noted that the NMF is redefining its focus as a centre of memory, and promoting dialogue on social issues. Living the legacy means more than just the implementation of programmes, but to achieve the founder's vision for a fairer and more just and humane society.

The intention is to draw on the rich traditions of transformative dialogue, problem-solving and social renewal that have made possible South Africa's remarkable transition, over a short period of time, from apartheid to an era of democracy and human rights. In that sense, the process could be seen as one of re-energising a constellation of forces that has already achieved radical systems change – in this case, to achieve the transformation of South Africa into a world-class leader in the struggle against HIV and AIDS.

There is no other way to look at complex issues other than to have a multistakeholder approach. Through dialogue, the Foundation intends to bring about deep conversations among all relevant system actors to develop a greater level of understanding and awareness about the problems they face and each person's role in a larger system of interactions.

The system actors are able to:

- Generate new alliances, collaborations, and solutions that go beyond traditional approaches.

The key challenges to dialogue are:

- To bring more voices in, not just the NGOs, government or the private sector into the conversation.
- To create trust among all key stakeholders.

The group found that the important issues to be considered in the short term in HIV and AIDS are:

- Define who the key stakeholders are – government, funders, etc.
- Ownership of HIV and AIDS.
- Move away from an expert-based approach, move out of comfort zones, and talk to other people who have no stake in the issue.
- Define the goal or end-point of the dialogue.
- What is the big picture?
- Task shifting.

In the case of HIV and AIDS the end-point could be universal and equitable access to care. It was felt that government is a key stakeholder in the dialogue process, although this may not be the case in all dialogue. Government is perceived as being defensive rather than open to discussion around its position by some key stakeholders.

It was felt that the dialogue should be around the whole health system rather than a narrow focus on ART models. Gaps in the health-care system were important to identify.

It was noted that, with the current challenges in the health system, it “cannot just be business as usual”.



Since other dialogue processes are ongoing, it is necessary to determine how the NMF dialogue process will differ from the others, and where the focus should be.

Principles should include:

- Concrete outcomes.
- Solutions rather than confrontation.
- All key stakeholders.
- NGOs and others should evaluate outcome rather than government.
- Forum to communicate issues.

In Summary

There is a need for dialogue to continue with all stakeholders beyond ART, but to have a broader perspective. The Comprehensive Plan for HIV and AIDS Care, Management and Treatment (CCMT) programme has brought new energy and resources into the system. There is a groundswell of activity and this needs to be capitalised on.

It is essential that we build on other dialogue processes that are in progress. The big group discussion added that the dialogue needs specific objectives. It is a tool, but not an end in itself. It is important to create spaces where anger and frustration can be vented prior to moving into dialogue.



Daniel Berman

“

A dialogue itself doesn't really necessarily have any value unless there's a framework of objectives. Like we are dialoguing because we want to achieve something or affect change, or whatever. I guess it's more of a suggestion: the Foundation needs to decide what change you guys are after. Maybe you already have and it's just my ignorance. Dialogue ... is a tool but it's not an end in itself.

”

Reflecting on the Process



Eula Mothibi

“

It was very different, the methodology used, but it lended itself to what happened. People opened up, spoke their minds and there was a lot of interaction. What I learnt the most was from others. I hope for those people struggling, they managed to get light and are able to change what they practice and change processes.

”



Kuku Appiah

“

The methodology used to have this meeting has felt uncomfortable at times; it's not the normal way. ... But people seem to be a lot more involved and awake in the process than might have been if we had followed the more conventional ways of having this type of meeting. So I think it's been a bit difficult but I think it's interesting to explore other ways of meeting and dialoguing.

”



Marga Vintges

“

Opportunities like this, for me, being rural and alone, are extremely important to think ... and to drink other people's ideas. We need to do this more often and maybe have a weblist.

”



Lynne Wilkinson

“

I know one of the catalysts for this meeting was MSF moving out of Lusikisiki. And I just want to say from our side, as a rural site, thank-you very much for everything we learnt from you. Because without you we would have really had to start from the beginning and you gave us insight as to where to go and I think it made the world of difference to our site.

”



Marianne Knuth

“

It feels like it's gone well. It's been productive and has brought out new ideas and insights. ... I feel we could have created more time for story-telling though.

”



Tandiwe Xozwa

“

I just want to thank you, the organisers and the facilitators, just for recognising the people from the deep rural areas. ... I'm just excited with the information and things which I've learnt from each of you.

”



Mothomang Diaho

“

I came to listen, I learnt a lot. Never underestimate what a small group of individuals can do to change the world.

”

Médecins Sans Frontières

Médecins Sans Frontières (MSF) was created in 1971 by a small group of French doctors. During the Nigerian Civil War, the Nigerian military had formed a blockade around the newly independent south-eastern region, Biafra. It was here that these French doctors first went to provide urgently needed medical help.

MSF is now an international humanitarian organisation that provides emergency medical assistance in over 70 countries worldwide.

The beginning of MSF's involvement in South Africa's HIV and AIDS pandemic was in May 2001 when three hospitals in Khayelitsha, Cape Town – Michael Mapongwana, Site B and Nolongile – started providing antiretroviral therapy (ART) to HIV-positive people. The therapy took place in HIV and AIDS dedicated clinics run by MSF.

In 2003, with the Nelson Mandela Foundation, MSF expanded its



programme to include one of South Africa's poorest communities, Lusikisiki, in the Eastern Cape. The *Siyaphila La* ART programme was launched by Nelson Mandela who administered the first pills to an HIV-positive woman. *Siyaphila La* means, "We are living here" in Xhosa.

Siyaphila La is recognised by the Eastern Cape provincial government as an official programme to initiate ART in the province.

MSF has achieved much in Lusikisiki, especially in terms of helping people to undertake HIV tests

and ensuring that they have access to ARVs that is well supported and managed. The project has seen a steady increase in HIV-testing in the area, as well as high levels of adherence among those on ART.

Despite withdrawing from Lusikisiki, MSF is committed to continue engaging in HIV/AIDS and TB activities in South Africa, as it has done for the last seven years.

In addition, MSF is getting ready to consolidate the presence in South Africa by starting a new partner section in the country. The new section will participate in the international MSF movement – currently constituted by 19 sections in different countries around the world – and will be deeply rooted in MSF's principles and values.

To drive this process, a new team is being recruited. The new office will be based in Johannesburg and is expected to open in November 2006.

Nelson Mandela Foundation

The Nelson Mandela Foundation (NMF) was established in 1999 to meet the immediate need of its Founder for a personal office on his retirement as President of South Africa. This role remains integral to the NMF, but following Mr Mandela's retirement announcement in 2004, the Foundation is in the process of converting its core function to that of a "Centre of Memory" capturing in perpetuity the life and times of the Founder.

The Centre of Memory, which will become operational in the course of 2007, has four main aims as endorsed by its Board of Trustees:

- The collection and curation at Mandela House of Mr Mandela's personal and other related archives.
- The provision of an electronic portal to global resources on the life and times of the Founder.
- Provision of public access to these



resources, and facilitation of related dialogues at Mandela House. The creation of a unique facility for researchers working on the life and times of the Founder.

The work of the Centre of Memory will complement that of the sister organisations, the Nelson Mandela Children's Fund (NMCF) and the Mandela Rhodes Foundation (MRF). The NMF will focus on memory and dialogue, and also reflect the focus of the NMCF (children and youth), and the MRF (leadership and capacity building). Together the three Mandela

legacy charities will express, in tangible terms, the key aspects of Mr Mandela's legacy.

The NMF has, in its seven years of existence, also made programmatic interventions in areas of concern to the Founder. These include:

- HIV/AIDS and health matters – initiatives include the 46664 campaign.
- Rural schooling – initiatives include the establishment of the Unit for Rural Schooling and Development based at the University of Fort Hare, and the 'Emerging Voices' project.
- Dialogue forums aimed at enhancing understanding of social development challenges and finding appropriate strategies for meeting them.

These important interventions are currently undergoing structural review so as to fit into the new Centre of Memory model of the NMF.

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