Decentralised and integrated comprehensive HIV care and treatment at the primary health care level in rural South Africa: The experience of MSF in Lusikisiki, Eastern Cape

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Programme developments

- Feb 03: Launch of the programme initial training on VCT and PMTCT
- Mar-Aug 03: Training of nurses on OIs & ARV’s
- Oct 03: First patient enrolled on ARV
- Apr 04: DOH takes over PMTCT programme and lab costs
- March 05: DOH takes over ARV supply from MSF and begin of programme hand-over
- Oct 05: 1000 patients on ARV
- Dec 05: Introduction of PCR and DBS for infant HIV testing
- Oct 06: Anticipated complete hand-over to DOH

Key operational principles

- Clinic-Based
- Nurse-managed
- Counselor-dependent
- Community-driven
- Patient-centered

Key operational strategies

- Strengthening existing systems:
  - Drug supply
  - Laboratory services
  - Infrastructure improvements
  - Referral systems and role of the hospital

- Developed monitoring and evaluation systems:
  - Tools for individual patient monitoring
  - Registers, cohort analyses
  - Clinic supervision tools: PET and CET

MOBILIZING HUMAN RESOURCES:

- Making better use of existing resources: infrastructure, nurses, CHW’s
- Creating new capacity: pharmacy assistants, adherence/treatment counsellors, clinic based CHW’s
- Supporting community mobilisation, advocacy (TAC)
- Alternative approaches to formal training: weekly presence of mobile team, on-site mentorship, regular supervision

Delegation of tasks

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<th>Task</th>
<th>Responsible person(s)</th>
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<td>Programme development</td>
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<td>Community involvement</td>
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Community involvement in clinic support

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<td>Hospital v. clinics</td>
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VCT coverage

- 90% people tested in 2 years (22% of client population)

Conclusions

Decentralisation vs. centralised approach (including "down-referral model")

- Increases uptake of HIV services due to geographical accessibility
- Eliminates waiting time ("queues")
- Improves monitoring of patients
- Reduces lost patients and records
- Empowers and engages clinic staff
- Creates new categories of health workers to cope with HIV-associated workload
- Facilitates integration of HIV/AIDS treatment into TB and PMTCT services at primary health care level
- Strengthens PHC system

Challenges

- Human Resources:
  - High attrition of nurses: need for incentives (specialised diploma)
  - Overcoming scope of practice issues for nurses
  - Creating new job categories for clinic-based CHW and adherence counsellors to be integrated in DOH system
  - Supply chain over-stretched:
    - Require strengthening of drugs supply system (stock coverage not acceptable)
    - Problem with transport to clinics (specimen collection)
    - Poor management at central medical stores
  - Need for ongoing quality control:
    - No agreement on monitoring and supervision tools

Lesson learned (Scott district Lesotho)

- Joint programme planning and management with counterparts from the start (CHAL/Scott Hospitals)
- Earlier training, engagement, and empowerment of nurses at the clinics (not only CHWs)
- Earlier initiation of HIV clinic supervision
- Constant attention to avoiding substitution/replacement despite constraints
- Earlier awareness of acute need for creative nurse motivation and retention strategies
- Commitment of Ministry of Health to provide all ARVs (OPATM funds) through existing supply chain management system

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