COPC analysis of intersectoral HIV AIDS work in Okhahlamba

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Introduction

Over the past 2 years a non-governmental organisation has evolved that facilitates intersectoral work in the HIV/AIDS field in the Okhahlamba Municipality. Okhahlamba Municipality is situated along the Drakensberg mountain range in KwaZulu Natal and is home to approximately 150 000 people. As in many rural areas of South Africa, the community is characterised by high levels of poverty and illiteracy and subsequent poor health status.

In trying to understand the process of setting up such an organisation, it has been useful to reflect on Community Orientated Primary Care (COPC) as a conceptual framework. By reviewing the beginnings of intersectoral work in relation to the COPC model, important lessons can be learnt for the future of the organisation.

Background to COPC

In 1940 Sidney and Emily Kark initiated an experiment at Pholela Health Centre in KwaZulu-Natal that led to the development of COPC (Tollman 1991; Tollman 1994). The process was based on a concept of linking curative medicine with a public health approach. An important aspect in the COPC process is that "local coopera-tion and community responsibility was to be developed wherever possible. The activities of the health centre were to be coordinated with those of other local agencies such as the authorities responsible for agriculture and education."(Kark 1951, p.665)

In the description of the COPC, Kark emphasized the importance of understanding the individual as an integral part of his environment, as well as recognition of the importance of nutrition, psychology and social sciences in the determination of health (Kark 1951). Sensitivity and deep understanding of local culture and economic dynamics were important aspects of how the Karks functioned in the Pholela area. COPC has been systemized into discrete steps, moving from a practice profile and individual patient to making a 'community diagnosis' and planning interventions at community level (Reid 2000). Repeated surveys to monitor the health and disease of the community are integral to the process in the methodology (Tollman 1991).

The key features of COPC are:

- Linking the experience of the individual to the larger context of family and community (including cultural and economic issues)
- Intervening at a clinical, family and community level
- Fostering a participatory approach between communities and relevant role-players in the planning, implementing and evaluating of programs
- Use of information (especially surveys) to assess health indicators and measure impact of interventions

Coordinating HIV AIDS work in Okhahlamba - Understanding the problem

Over the period of 2000 - 2002, the local AIDS Action Team of the health sector was coordinating the activities around HIV AIDS work in the catchment population of Emmaus Hospital. Box 1 lists the participants of the Team. (The author was the Medical Officer in the team.)

The team was meeting monthly and in the process attempted to improve the relationships between different levels of care (home-based care, PHC clinic, Hospital) as well as to improve the referral system. From the surveys that had been conducted in the community by the Child Survival Project and the Department of Health, the following information became apparent:

- HBC is very acceptable and appreciated by the community (UThukela District Child Survival Project 2002)
- There was a high level of knowledge about HIV, but poor behavioural change (UThukela District Child

Box 1: Team members of the AIDS action Team

PHC coordinator	HIV coordinator
Home-based care coordinator	Child Survival Project (local NGO)
Emmaus Hospital PHC sister	VCT counselors
Emmaus Hospital Medical Officer	PHC clinic sisters

Box 2: Hlengiwe's story

Hlengiwe was weak and emaciated when she was brought to the hospital by a visiting uncle. He was shocked at her condition and 'wanted to do something for her'. She was admitted to female ward where she was treated for chest infection and improved slightly, although remained weak and wasted. She 'refused' VCT while in hospital and was soon discharged. The doctor wrote a letter for home-based care, which she forgot at the hospital when the sister who cared for her picked her up. However, a neighbour had referred her to the home-based carers already.

Although the Doctor had filled in a form to try and apply for disability grant, she did not manage to go the welfare offices to fill in all the forms as she has been too weak. There is little food at home and since she was ill she has not managed to work as a farm labourer. The sister has been looking after her has struggled to cope as he was becoming increasingly ill and she has her own family to care for. She had also taken Hlengiwe's 3 children with her to her home.

Box 3: List of organisations participating in the intersectoral meetings

Dept of Health	Churches (4 denominations)
Dept of Welfare	Traditional Healer Organisation
Dept of Education	Wellbeing center (support for HIV + people)
SAPS	Home-based care organisation
Dept of Agriculture	Ekuphileni (orphan care)
Dept of Correctional Services	Local Youth group
Local Government	Mathew 25 (church-based welfare org)
Dept of Tourism	Lovelife youth center (Gugulethu)
Government Communication and Information System	
COUNT (Literacy NGO)	Christian Listeners (supporting HBC)
Farmers Support Group	Ubuntu partners (faith-based welfare org)
HIVAN (HIV research org)	

Survival Project 2001)

- The referral system between different levels of care in the department of health as well as agencies outside of the department of health was not working well (evidenced by repeated discussions at the meetings)
- Many needs outside of the health sector (UThukela District Child Survival Project 2001)

At a meeting in 2002, a review of the work to date took place. A number of frustrations had arisen also from a strong sense that the team was failing to meet the needs of the patients. This was illustrated by anecdotes of individual patients shared by a number of participants (e.g. PHC nurses, VCT counsellors, HBC coordinator, doctor). Box 2 narrates one such story

The 'diagnosis' that we came to after reflecting on the information available to us (as well as the anecdotes such as the story told above) included the following:

- People are suffering and we often feel helpless
- We do not understand all the aspects of the care – what is going on at home and how decisions are made
- Many aspects of care are 'no-man-zone' – no one is responsible for pulling the care together and looking after the person holistically.
- There are many failures within the health sector to work closely together
- Families are often not involved when interacting with the formal health services
- Other sectors should be involved to address the needs of people with HIV AIDS

Attempts at solving the problem

Out of the review, one of the aspects that became obvious was that other sectors would need to be involved in order to provide more integrated care to people affected by HIV AIDS. A brainstorm about the stakeholders in the support and treatment of people affected by HIV AIDS identified a long list of organisations. Two participants from the team (including the author) were asked to take the lead in contacting the organisations and inviting them to a meeting to explore working together.

At the first meeting approximately 40 people attended from a wide range of governmental departments and community organisations. At the initial meeting, current activities and service offered by each of the organisations was shared. This generated a lot of enthusiasm and immediately contacts were made and phone numbers exchanged. Participants expressed surprise about the number and extent of resources available in the area.

Due to the success of the first meeting, it was resolved to meet on a regular basis. The initiators of the first meeting took the responsibility to coordinate future meetings and involved as many organisations as possible. The purpose was to support coordination and potentiate what individual organisations were doing already by placing them in a wider network of services. A number of organisations only started to attend once it became more obvious that the meetings were useful for a wide range of groups. (Box 3 shows the list of organisations that participated in the meetings over the past 18 months.)

The meetings took place 1 to 3 monthly, depending on the situation in the area and workloads of the participating organisations. The number of participating organisations also varied and to some degree depended on the commitment and vision of the individuals that were part of the meetings. Out of the meetings, it became evident that the regular meetings were playing an important part in the service provision as many organisations had little contact with each other outside of this forum. It was therefore decided to form an NGO (called Philakahle/Wellbeing) to coordinate the HIV AIDS work and particularly to support community-based organisations in the area.

Intersectoral work – analysis of current situation

In order to assess the success of the intersectoral work that has been initiated and to provide direction for the future, a 'SWOT analysis' (analysis of strengths, weaknesses, opportunities and threats) was done to explore the current situation. In this SWOT analysis the key aspects of the COPC model discussed above are used as a guide to assess our initiative.

Strengths

- A lot of information regarding the situation is available and is being shared at the intersectoral meetings
- Contacts have been made between organisations
- It seems obvious to work together – the whole is greater than the sum of the parts.
- Many government departments and community- and faith-based organisation are involved and have pledged continued engagement
- The focus is beyond the medical aspects of the patient; it includes community-level initiatives and economic support

Weaknesses

- There is poor coordination of services despite meetings
- It is difficult to achieve joint planning as accountability of individuals is to their parent organisations and there are different systems operating in different organisations
- Intersectoral work is no-bodies (?nobody's) work – no one is accountable for whether it works or not
- Not everyone 'found a place'; some sectors (especially that are close to patients, e.g. traditional healers) are not central in the approach
- When focussing on organisational aspects of the intersectoral work it is easy to forget the person and the

families at the centre of our work.
- Many aspects of care are not well understood and addressed
- The link between clinical care and broader support and follow-up is still weak

Opportunities
- A new organisation has been formed with a mandate to coordinate HIV AIDS work
- There is little precedent which allows for innovation and new ideas to be implemented
- Many organisations are participating with a wide scope of interests and skills, with the possibility of greater involvement

Threats
- Some smaller organisations fear being 'taken over'
- A new bureaucracy may be established that perpetuates the inaccessibility of service
- There may be a loss of focus on individual patients' needs
- There may be divergence of expectations amongst role-players

Way forward

From the SWOT analysis, it is evident that while a lot of work has been done already and real success has been achieved, there are a number of weaknesses in the approach. The involvement of the client and linking the experience of the client and their families to the broader intervention is an important area that needs to be explored and developed. From the health care sector's perspective, linking the clinical care with the larger intersectoral work, is a further challenge.

The challenge for the new organisation is to develop clear relationships with each of the participating organisations and identify the 'merged agenda'. Important in the process is to maintain the focus on the client and his/her family that we want to assist, rather than to be obsessed with the organisational aspects of the work. Strong leadership that encourages the community and 'client-voice' will be a prerequisite to achieving the goal of integrated care for people affected by HIV / AIDS in the community.

Dr Bernhard Gaede is currently working as a medical officer at Emmaus Hospital and is a director in the NGO, Philakahle / Wellbeing, coordinating HIV AIDS work in the Okhahlamba Municipality in KwaZulu-Natal.

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FIRST DUMO BAQWA AWARD

The first Dumo Baqwa award was awarded at the annual conference of the Rural Doctors Association of Southern Africa (Rudasa) in September 2004 to Dr Bernhard Gaede for his article about the establishment of a community based organisation, Philakahle, doing HIV AIDS care in Okhahlamba.

The Dumo Baqwa Award is dedicated to the memory of Prof Dumo Baqwa who died in 2001. Dumo was the Head of Primary Health Care at the University of Cape Town at the time of his death.

This award is the brainchild of Prof. Jan De Maeseneer from Ghent, Belgium. Jan and Dumo met in London in 1995. Their meeting was that of 2 people with a lot in common in their personal history and their commitment to action for more justice and equity world wide. Dumo invited Jan to Cape Town where he showed him the situation in the townships and the need for Community Oriented Primary Care. They were instrumental in the formation of the Family Medicine Education Consortium (FaMEC).

As Dumo Baqwa passed away in 2001, he could not be part of the further development of co-operation between Belgium and South Africa. So it was decided, in memory of this most inspiring person, to create the Dumo Baqwa Award.

The Award consists of an amount of 1000 Euro and is financed by the Flemish Departments of Family Medicine. It is given on a yearly basis to a post graduate student who completed his/her training in family medicine in South Africa. The candidates are required to submit a draft journal paper on a topic that is relevant for the demonstration of the importance of community orientation in family medicine and the link between family medicine and community health development. The paper must be based on work done with the significant involvement of the author and should focus on the community orientation in family medicine. During the first three years the VLIR-project "Own initiatives" EI-SEL 2003-14 will participate in the financing. Prof Baqwa's daughter, Nosizwe Baqwa, presented the award in Tshilidzini to Bernhard. She spoke about her father and his passion for the needs of people in townships.

Bernhard is currently working at Emmaus Hospital. Since his student years he has been involved in community activities and, as a medical student, he was very involved in the Muldersdrift Clinic. He has been a facilitator in district development, medical manager of Emmaus hospital, but nowadays he is back to mostly clinical medicine at Emmaus Hospital. Bernhard is an active member of Rudasa and is also an honorary lecturer at both the Universities of Pretoria and KwaZulu Natal.

The article describes the process of mobilising different organisations in the rural KZN community to collaborate in improving care to people suffering from HIV and AIDS. Recognising the contribution made by the community to his receiving the award, Bernhard requested that the 1000 Euro award be donated to Philakahle, the organisation formed in the project.

Prof Jannie Hugo