RURAL ARV PROVISION – POLICY IMPLICATIONS FOR ACCELERATED ARV ROLL-OUT

Reflections on a national dialogue on rural ARV programmes

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As the Médecins sans Frontières (MSF) project of setting up ARV provision in Lusikisiki, Eastern Cape, draws to a close after 3 years (as reported in a separate article in this edition), the Nelson Mandela Foundation and MSF organised a 2-day dialogue to explore antiretroviral (ARV) provision in rural South Africa. What follows are some reflections on the 2 days – it is not meant to be a report-back (indeed, a publication based on the proceedings is available free of charge from the Nelson Mandela Foundation[1]). I would rather reflect on some issues that arose from the meeting that were particularly poignant from the perspective of trying to provide a good-quality ARV service in a poor rural community. Some of these have implications to review national legislation and policies to make them more 'rural ARV roll-out friendly'.

From the presentations and the discussions over the 2 days of the dialogue it was striking how many services in rural places in South Africa have managed to provide ARVs to an amazing number of people. It was incredible to see such diverse people, managing to provide life-saving medication in situations that a few years ago were deemed 'too difficult' even to be considered as part of the ARV roll-out. From the presentations it was evident that ARV provision in rural areas is not only possible, but very realistic – even in very resource-constrained settings. Some of the rural projects have been profiled in previous editions of the *SA Journal of HIV Medicine*.[2,3] Besides the Lusikisiki experience, the discussions drew on the experience from sites among others in Madwaleni, Klerksdorp, Mseleni and Bergville, and projects including Right to Care, ARC, the International Center for AIDS care and treatment programme and others. Many of the participating sites show high rates of initiation of ARVs per population, with good quality of care indicators such as adherence rates. Innovative approaches from the experience of the participants include involvement of private general practitioners and NGOs, the use of mobile clinics and the involvement of academic institutions. However the input from MSF on their work in Thyolo district in Malawi was probably the presentation that was most remarkable, demonstrating how a successful ARV programme can be run in even more resource-constrained settings than rural South Africa.[1]

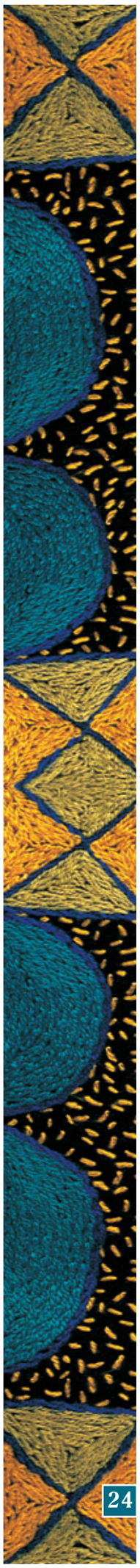
All of the projects had strong local leadership that was prepared to find innovative solutions to real problems experienced – even if it meant going beyond the guidelines and trusting that the spirit of the ARV roll-out was being followed. However, from the dialogue it was clear that there are lessons in the collective experience that are more universal than just a few mavericks going overboard on a personal mission. The lessons from the ARV programme in Thyolo, Malawi, further point to important policy issues that influence the ARV roll-out in rural areas. How did they achieve such success?

ARVs AT PHC LEVEL – INTEGRATING ARVs INTO THE HEALTH CARE SYSTEM

INTEGRATION WITH PHC – REVISION OF THE DOCTOR-DRIVEN SYSTEM

The current design of the ARV programme relies heavily on doctors in accredited ARV clinics to provide the medication. Experience in the roll-out has shown that this approach is not sustainable for the number of patients who require ARVs and increasingly services 'down-refer' patients to primary health care (PHC). Essentially PHC is the level of care where most patients end up, even in the design of the current system. The doctor-centric model with a vertical ARV programme needs to be revised.

Some of the most successful rural projects have achieved a high level of horizontal integration of the ARV programme into existing PHC services from the start. Patients are assessed, do the adherence training and are initiated on ARVs at the peripheral clinics by doctors and nurses. This has minimised the requirement of many additional resources that have been difficult to attract to rural areas. As many of the rural sites have shown, such an approach can lead to significant improvement of support to the clinics, as laboratory services,



transport and doctors' visits to the clinics improve. Even though a large degree of variation was noted between the different approaches, the integration of ARV services into PHC level of care is key in the success of many of the projects.

SCOPE OF PRACTICE FOR PHC NURSES

Following on from the above, areas that have very poor doctor/population ratios are unlikely to see local ARV programmes as defined in the current guidelines owing to the high degree of doctor-centricity. The increased integration of the ARV service with PHC level of care would have many implications on policy, particularly prescription and initiation of ARV medication by PHC nurses. Tuberculosis management is currently a mostly nurse-driven process that includes drug initiation and case management. While the TB programme has a lot to learn from the ARV roll-out (such as adherence training and moving from 'compliance' to 'adherence', community mobilisation, etc.), the ARV programme has a lot to learn from the TB programme. A system with strong protocols, regular review of quality of care (case reviews) and strong local support for nurses would make ARV initiation a good-quality option for ARV provision in resource-constrained settings.

ROLES OF PERSONNEL – TASK SHIFTING

A key area that has added to the success of many projects is to clearly define roles of many health care workers, with less reliance on professional nurses or doctors to do most of the administrative tasks. In one project enrolled nurses (who are less scarce) were used as 'HAST nurses' who ensured that all TB and ARV patients at the clinic had all their paperwork sorted out, guided the patients through the maze of tests and medications, and ensured that defaulters were traced. Similarly, in many projects the VCT counsellors do much more than VCT, but are involved with checking adherence, giving nutritional advice and performing many of the administrative tasks. In other ARV programmes, community-based organisations or volunteers have partnered with the health service and help to perform some of the supportive and administrative functions. Such approaches are achieved within current policy framework and funding.

COMMUNITY INVOLVEMENT

Shifting from viewing the community as passive recipients of 'care' to active participants in the shaping of their future – a shift towards much greater community mobilisation for their health is vital. Building relationships with the community structures of home-based carer groups, church groups, local youth teams, etc. is a good start. But the relationship needs to include clear functions that have an impact on the wellbeing of the community. Arming them with good information is vital, and mobilising them towards universal testing and universal access to ARVs can be a powerful ally in the development of a strong local service. When the community starts to demand a good service (and can articulate what it expects) the service invariably improves. The success of ARVs in individuals is a powerful message in itself. Community involvement of this sort is strongly supported in the current national guidelines of health promotion.

COMMUNITY-LEVEL VCT – SUPERVISION FOR VCT COUNSELLORS

According to national policy for VCT, currently the VCT counsellors cannot work independently as the HIV test has to be verified by a professional nurse or doctor. This is interpreted differently in different provinces – in some provinces this means that the VCT counsellors are not allowed to 'prick' a person to draw blood to do the test, in others it means that the confirmatory test has to be done by a nurse or doctor, while the screening test can be performed by a VCT counsellor. In practice the policy means that community-level VCT is virtually impossible, as professional nurses and doctors are already scarce resources to cope with the clinical work in the hospitals and clinics.

In order to reach good coverage rates of ARVs in a population, a significant proportion of the population needs to know their HIV status. In some of the sites the rate of VCT uptake is becoming the rate-limiting factor in initiation of ARVs. Allowing VCT counsellors able to test to do so without needing confirmation of the test by a professional nurse would make community-level VCT possible, thereby improving the availability and rates of testing. Many NGOs have VCT counsellors who currently cannot test for HIV, as they do not have the professional nurse to confirm. VCT counsellors could be linked to TB tracing teams, home-based care systems, community health worker programmes and other community-level initiatives.

The deployment of VCT counsellors at community level would require further training and orientation, developing good support for the counsellors as well as good referral systems to access CD4 counts and ARV services. Such a step would require the scope of practice for VCT counsellors and their supervision to be revised.

ACCREDITATION

The current accreditation process poses a barrier to some sites in starting ARVs, particularly if they try to implement a PHC model of providing ARVs. The administrative processes required and the poor co-ordination between local, provincial and national processes (and access to resources) were raised as an area of frustration. Many items in the accreditation process are based strictly on the initial guidelines of the roll-out plan, which by now has been widely adapted and simplified. If the roll-out of ARVs is a priority and should be accelerated, the process of accreditation (and indeed support following the accreditation) needs to be evaluated and streamlined. The process of accreditation should also emphasise the need for integration with PHC from the start, rather than making 'down-referral to PHC' an afterthought in the design of the system.

DISTRICT HEALTH SYSTEM (DHS) IN ACTION – STRENGTHENING PHC

Essentially what is being described above is the DHS in action using a PHC approach, not only in its mechanism but in the

PHC philosophy. It ensures local flexibility, sensitivity to the local context and capacity to respond creatively to challenges. The Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa[4] states explicitly and repeatedly that its implementation seeks to strengthen and improve the DHS and even seeks to 'avert development of vertical systems of care' (p. 55). This challenges how the ARV roll-out has been managed up to now – as a vertical programme that has not been integrated much into PHC level of care in most sites.

Many of the operational and policy issues need to be addressed in this context, and with a few clear policy decisions as outlined above, radical acceleration of roll-out is possible. Strong and clear leadership to change the policies at national and provincial level and bold leadership at local level to implement the changes will be a decisive factor in the success of programmes.

CONCLUSION

Rural areas are generally neglected and struggling with lack of resources and are often viewed as 'lost causes'. However, these sites show the way to implement what is intended in many of the policy documents and the strategic thinking. However, the implications for the wider implementation of a rapid rural ARV roll-out touch on legislative issues, regulations and guidelines, as well as many organisational challenges. But all of the acts, regulations and guidelines need to be viewed in the context of a global disaster, and the legal and regulatory framework needs to be changed to ensure a dynamic and sustained response to the crisis.

I would like to thank all the participants in the dialogue at Maropeng for their openness, rigour and clarity. It was a privilege to have participated.

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