Rural Doctors Association of Southern Africa

Rural Health Advocacy Project

SUBMISSION BY THE RURAL DOCTORS' ASSOCIATION OF SOUTHERN AFRICA (RuDASA) AND THE RURAL HEALTH ADVOCACY PROJECT (RHAP) TO THE SOUTH AFRICAN NATIONAL AIDS COUNCIL ON DRAFT ZERO OF THE NATIONAL STRATEGIC PLAN (2012-2016)

RuDASA is an organisation of health professionals, primarily doctors, with a vision to inspire others to rural health and improve the health of rural communities in Southern Africa. The Rural Health Advocacy Project is a partnership between RuDASA and Wits Centre for Rural Health and SECTION27. The main aim of the RHAP is to advocate for equitable, quality health care to rural communities.

We welcome the opportunity to make a submission on the National Strategic Plan 2012-2016 Draft Zero.

We note the contributions of other organisations, such as Medecins Sans Frontieres (MSF), Amnesty International and our partner organisation Section27, which have been shared with us. We will not repeat the points they have already raised. We support these submissions, and in particular we wish to emphasise the points raised by the submission of Amnesty International, which speaks to the challenges of access experienced by the rural poor.

We wish to raise certain further issues which we believe will help to "rural-proof" the plan and improve its relevance and effect in the rural areas of South Africa.

Focus on rural challenges

The NSP Draft Zero notes (page 21) that there has been a 3% decrease in the prevalence of HIV in urban areas during the past five years, but during the same period, an increase of over 5% in rural areas. This, however, is the only reference to rural areas in the whole draft.

Rural areas present their own specific challenges, including the fact that rural communities are often poorer, less educated and face greater geographic and socio-economic barriers to care. In addition, the health service in rural areas is often even more under-resourced with both staff and supplies, compared to urban areas. Challenges are exacerbated by the greater distances from provincial or district offices.

These realities need to be taken into account when planning how best to deliver HIV and TB services across the country. The explicit acknowledgement would help focus attention on the specific challenges that are faced.

Vulnerable populations

Further to the above comment, we request that rural communities be added to the list of vulnerable populations requiring special attention (page 36). Rural communities need more explicit gender support for women and orphans and vulnerable children, wider prevention messages spread through traditional networks and greater emphasis on community based ARVs (including pre-packaged medication and innovative adherence models) due to the barriers mentioned above.

Chapter 7.7 on Pillar 3 (page 61) could be similarly strengthened by explicit reference to rural communities as a vulnerable group. In addition to the specific factors already mentioned that impede access to services, rural communities are often less aware of their rights. This makes them more in need of the same kind of targeted interventions mentioned in section 7.7. Each intervention, as planned, should be measured against whether the plans will successfully meet the needs of the members of each vulnerable group who live rurally.

In addition, the needs of mobile and migrant populations (page 36) should specifically refer to rural people who migrant between their homes and the cities, and make mention of the need to proper continuity of care in addition to the other factors mentioned.

Strategic enablers

We support the key strategic enablers mentioned for pillar 2 (page 38), but would like to see them strengthened by adding that models should be rural-friendly, with specific support for pre-packing drugs and using community health workers in distribution thereof.

The strategic enablers for pillar 3 (page 38) also acknowledge the important role of law enforcement agencies in protecting vulnerable people. In some rural communities there is still widespread acceptance amongst police of violence (including abduction and domestic violence) against women, with complaints settled outside of the law by adopting “traditional solutions.” A mechanism for better monitoring how police handle incidents of rape and abduction would strength how rural communities benefit from this clause.

Innovation

We support the call for innovation in section 8.3 (page 75). This is especially important in rural communities, each of which may face its own unique challenges and dynamics. We believe that innovation can be nurtured and protected by clearly defined objectives (for example, that people should be able to access treatment at their local clinics), which can then be interpreted and implemented differently depending on local constraints and context.

Task shifting and training

We strongly support the concept of task-shifting (page 13), but feel that the policy of mentoring nurses needs to be emphasised in Draft Zero. Mentoring is especially important in rural areas as professional nurses tend to be more isolated than their urban peers, with fewer people to ask for help and worse access to telecommunication.

The capacity development envisaged in section 8.2 (page 74-75) is supported, but emphasis should be given to training people at their place of work wherever possible. Regional training centres need to be more proactive and promote site based learning rather than expecting participants (usually a

small group of the same managers) to travel in from remote sites – a practice that removes services from people and wastes time.

Environmental controls
The importance of adequate infrastructure in ensuring proper infection control is identified in Draft Zero (page 42). Many facilities, especially in rural areas, still have poor or inappropriate infrastructure which makes proper infection control difficult or even impossible. This needs specific budget allocated to it to ensure this can be dealt with by 2016.

Drug supply challenges
Draft Zero makes only indirect references to the challenges of drug supply. In many rural areas obtaining a reliable supply of medication (of any description) is an ongoing challenge. Mechanisms need to be put in place to address this and ideally a central coordinating office where stock-outs of "red list" items (to be determined) can be reported, established and widely advertised.

Communication
Communication is often a major challenge in rural areas. This is recognised in various places in Draft Zero.
We support the statement that coordination between national strategy and implementation needs to be strengthened (page 15). Leadership and the governance structures envisaged in section 8.1 (page 73) are important to ensure that there is better coordination and communication between levels, better cascades of information and that local, district and provincial structures facilitate implementation without delaying it. A mechanism to feedback from the coal face of the "side effects" of policy – such as how it is often misinterpreted or misapplied on the ground – would help improve communication and give substance to the intention to be "informed by realities on the ground." (page 75). This will, additionally, inform future policy and training.

Pillar 4
Pillar 4 deals with some challenging but important concepts. We think that included in this pillar should be plans to explore further the beliefs rural people in particular often hold about HIV, circumcision, breastfeeding and general health, to mention four.

Additionally, we think an objective under pillar 4 should be to work to develop a sense of agency and self-worth particularly in the youth.

Research (Chapter 10)
Specifically rurally conducted and focussed research should be added to the relevant items mentioned under research agendas for the different pillars on pages 81-83. Rural communities have different challenges, needs and dynamics to urban communities and research needs to take this into account.

Quality of services
We strongly support the emphasis on improving the quality of services offered (page 53). We note with concern that implementation in some rural areas lags behind urban centres and that in an effort to catch up there is a massive push to get people onto treatment, without adequate attention

to quality. The proper monitoring of care and tracking of patients in areas where infrastructure is poor and distances often larger requires attention and emphasis.

Some further comments

TB targets (page 37)

- Reducing new infections to 2010 by 2016 is not very ambitious – we should seek a further reduction.
- Specific targets to reduce the lag time between diagnosis and initiation of treatment in drug resistant TB are needed in addition to the target to get more diagnosed DR-TB patients onto treatment.
- Improving the cure rate to 85% is in line with WHO goals, but the reality in the era of sputum negative TB (which is common in people co-infected with HIV) is that this indicator is insufficient as a marker of success. A specific target to reduce defaulter rates would be a helpful adjunct.
- The implementation of the national plan to decentralise care for MDR-TB patients (page 25) needs targets to be included in this NSP to further strengthen integration of TB and HIV care.

TB infection control (page 42)

The importance of infection control in the community – especially ventilation in rural homesteads (and peri-urban settlements too) should be added as the majority of new infections occur in the community.

Care and treatment for children (page 53)

Adolescents infected with HIV are a group which will increase in size in the period under consideration as children started on treatment live to be teenagers. Specific attention needs to be paid to adequate disclosure and proper support for this group of people to ensure proper care and adherence.

Single national identifier (page 43)

There is a critical spelling mistake in point three (identifier). This useful idea needs to be carefully implemented, especially in rural areas where many people still lack identity documents.

Circumcision and PMTCT (page 40)

It is not clear why circumcision should be part of the PMTCT package instead of the general newborn care package. It is not part of preventing mother to child transmission and should be offered to newborn males of HIV negative mothers too.

Circumcision and task shifting (page 40)

- The role of task shifting to adequately achieve medical male circumcision targets in rural areas needs to be more fully explored.
- Better engagement with traditional structures and traditional circumcision practices holds potential for not only improving rates of male circumcision, but for improving the safety of traditional practices.

Point of care testing

Point of care testing is mentioned in the tables on pages 48 and 56. This technology needs to be made available in rural areas as a priority as the potential for impact on patient lives is greatest, despite the fact that overall numbers may be smaller.

Disabled populations

Disabled people are not mentioned at all in Draft Zero. We believe they should be added to the list of vulnerable populations on page 36 as their needs also require specific measures to address them. In rural areas, access for the disabled can be particularly challenging. Access to proper treatment also includes access to rehabilitation services. The latter are also not mentioned in Draft Zero, but should be included in this context if we wish to comprehensively address the needs of HIV positive people, particularly the disabled.

Monitoring and evaluation

- Others have made more detailed submissions, which we don't intend to repeat.
- We are concerned that the number of data elements is far too many to be realistically and accurately captured at clinic level where resources are poor. We should concentrate on fewer data elements and do them well.
- Data needs to be fed back to the end user. At the moment the flow of information is almost entirely one way.
- The integration of electronic HIV and TB registered should be pursued if we are serious about integrating HIV and TB care.

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