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That’s it: Together there is hope!

Background
Throughout the world, poor people and those from disadvantaged social groups suffer more illness and die sooner than the more privileged. Poor and socially excluded people face greater exposure to many health threats, and when they get sick they are much less likely to receive adequate care. In the health sector, particularly with respect to Tuberculosis (TB) and Human Immunodeficiency Virus (HIV) /Acquired Immune Deficiency Syndrome (AIDS), poverty represents a principal barrier to health and health care. While TB and HIV/AIDS are not exclusively a disease of the poor, the association between poverty and TB is well established and widespread” (Stop TB Partnership, 2002). TB/HIV thrives in conditions of poverty and can worsen poverty.

TB and HIV are described as a syndemic because they interact to increase disease. Despite the accumulated knowledge of the last two decades, the world has neither been able to contain the spread of HIV nor the illness and death that result from destruction of the immune system in those infected with HIV. Although TB is a preventable and curable disease, it is a leading cause of death among people living with HIV. Moreover, South Africa has the second largest incidence of TB in the world with more than 350,000 cases of TB that are currently being treated and at least 60% of these are co-infected with HIV (World Health Organization, 2011). It is important to start all HIV positive TB patients on Anti-retroviral treatment (ART) as soon as possible as it is the best protection against developing TB disease. In rural populations, access to ART, even though ART coverage is generally increasing, remains a challenge. Furthermore, a recent study investigating urban-rural inequalities on access to antiretroviral therapy in South Africa found that on average, rural users took more than double the amount of time and three times more in transport costs to reach ART service than urban users. They were also four times as more likely to fall in the poorest half of the economic index, borrowed money to pay for health
care and significantly more likely to report difficulty in meeting health care costs (Schneider H et al, 2010).

TB and HIV present a significant challenge to rural development. In order to improve treatment outcomes in both TB and HIV, that’s it, an integrated TB-HIV project based on a best practice approach, was developed and implemented collaboratively between the Medical Research Council and the Foundation for Professional Development. Started in 2005, this PEPFAR funded that’s it [TB, HIV/AIDS Treatment, Support and Integrated Therapy] project has had a particular focus on improving access to TB/HIV services for the most vulnerable rural populations as the impact of the TB/HIV epidemic on poor rural populations can be felt most dramatically in areas of entrenched poverty, food insecurity, and lack of educational and economic opportunity.

that’s it Methodology

that’s it promotes providing integrated TB and HIV care to all TB and HIV+ patients. Its mission entails that integrated TB/HIV care will be provided by the introduction of a “one-stop” shop for patient care by supporting human resources, infrastructure, capacity building, community outreach, recording and reporting, clinical interventions and technical support. The that’s it project works hand in hand with the Departments of Health in nearly 150 sites across four supported Provinces in South Africa—Eastern Cape, Kwa-Zulu Natal, North West and Western Cape—especially to provide access to integrated TB-HIV care that is easy, efficient, appropriate and cost-effective. Guided by the motto, “Together, there is hope!” the that’s it approach involves the patient, the health care giver and the community and reaches out to those most vulnerable, hard-to-reach populations to improve health care delivery involving a holistic approach which includes the development of nutritional gardens and nutrition education as well as psychological support to both health care givers and receivers.

Project Goals

• Integration of TB/HIV services: Providing HIV Voluntary Counseling and Testing (VCT)/ Provider Initiated Counseling and Testing (PICT) to TB
patients and TB screening to HIV+ patients; by accreditation of sites and increasing down-referrals; provision of mobile TB/HIV services; integration of patient files [1 patient, 1 file, 1 entry point, 1 exit point]

- Increased case finding: by community awareness campaigns; patient education; clinical interface with patients; early diagnosis/contact referral; laboratory support; decrease stigma
- Improved clinical care: by providing HR support and pharmaceutical support; nutrition interventions; equipment; appropriate treatment and care; linkages with other NGOs
- Infection control: infrastructure support; refurbishment and expansion of space (park homes); Infection Control practices
- Information management: introduction of that’s it forms and integrated patient file; implementation of integrated TB/HIV that’s it spreadsheet
- Improvement of National TB Control Program indicators: training of HCWs in recording and reporting; TB/HIV integration; TB technical support; improve adherence
- Interactions with communities: address stigma; produce awareness and community mobilization campaigns; school outreach activities
- Research: disseminate findings of best-practice implementation; operational research studies

Operational Framework

One-stop service for TB and HIV+ patient care [Illustrated in Figure 1.]

- HIV counselling & testing (provider-initiated): TB as entry point to services
- Regular TB screening for HIV+ patients: HIV as entry point
- Clinical care component including prophylaxis, referrals (Sexually Transmitted Infections, Prevention of Mother To Child Transmission) and nutrition, Opportunistic Infections, ART, Clinical Mentoring
- Infection Control focus (including infrastructure)
- Community outreach focus – to address the dual stigma, education, training, linkages and follow-up; nutritional gardens
• Health systems – Patient management system, data capturing, recording and reporting, improved patient flow systems

Figure 1.

Facility-based Activities
The project employs area managers and clinical site coordinators who regularly visit supported clinics, liaise with clinic staff to determine their training needs, and assess additional resource requirements to improve patient flow and facilitate comprehensive management of patients infected with TB and HIV/AIDS. This facility-based support has promoted TB/HIV integration and communication between that’s it, DOH management and clinic staff. Through the FPD and MRC, that’s it provided a range of TB and HIV/AIDS training support, for clinic staff. that’s it also provided TB focal nurses and data capturers and community counselors to provide Direct Observed Therapy (DOT) support and community tracing of lost to follow-up/default patients.
Community-based Activities

that’sit trained and employs a team of community care workers who engage community members, including community youth and traditional healers. In particular, referral networks, comprising trained volunteer community members were established for rural KZN. The functions of the community care workers and referral networks included tracing patients who had defaulted clinic appointments, collection and delivery of patients’ medication, and encouraging HCT and TB screening in communities. Due to transportation challenges, home-based collection of sputum specimens is done on completion of TB treatment to reduce clinic visits. Care workers facilitate support groups for HIV+ and ART patients to provide adherence support. They also facilitate referrals of patients for other services such as those provided by the Department of Home Affairs and the Department of Social Welfare. There have been numerous reports, by patients, of community workers providing patients with food and assisting with cooking, cleaning and personal hygiene. Clinic staff value the community care workers as they strengthen communication between the clinics, patients and communities. that’sit has also initiated other community-based activities such as training and assisting patients to establish household gardens, and TB education in schools and to taxi commuters.

Results

Over the last five years (2007-2011), that’sit project implementation efforts have resulted in an increased uptake of HIV counseling and testing for TB patients, improved clinical outcomes, and enhanced community participation in the care of patients living with TB and HIV/AIDS. The combination of facility-based and community-based activities by that’sit led to an increase in HCT of TB patients from 1,389 in 2007, to 26, 286 in 2011. A significant increase in the treatment of TB/HIV patients with 2,032 TB/HIV co-infected patients treated in 2007 as compared to 18,951 treated in 2011. Initiation of patients on ART has consistently increased from 2007 to 2011. Importantly, provision of VCT to the community at large has sky-rocketed from nearly 4,000 tests done in 2007, to over 150,000 done in 2011 [Table 1].
Table 1.

Conclusion
Access to basic health care services in rural areas is challenging due in part to the spread-out rough terrain, lack of transportation, poor infrastructure, scarce skills and deep poverty in many of the communities. Within this context, the main focus of that'sit has been on TB/HIV integration skills development, clinical capacity building and infrastructure support, and community engagement in these vulnerable under-served areas. The successes of the that'sit project are remarkable and replicable. Many lessons can be shared especially with others working to serve rural communities. If universal ART coverage and 85% TB cure rates are to be achieved in South Africa, rural challenges must be addressed.
References


