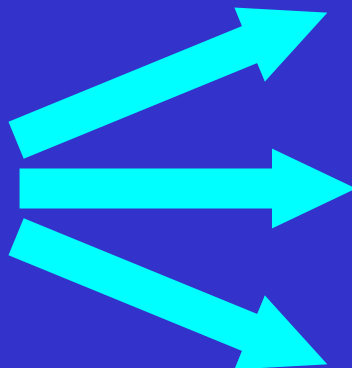
The KHAYELITSHA experience

A township 30 km from Cape Town

EST.99: 350,000 inhabitants

MSF – South Africa
Project objectives

Clinical programmes

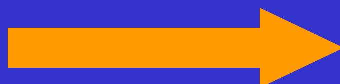


MTCT

Infectious disease clinics

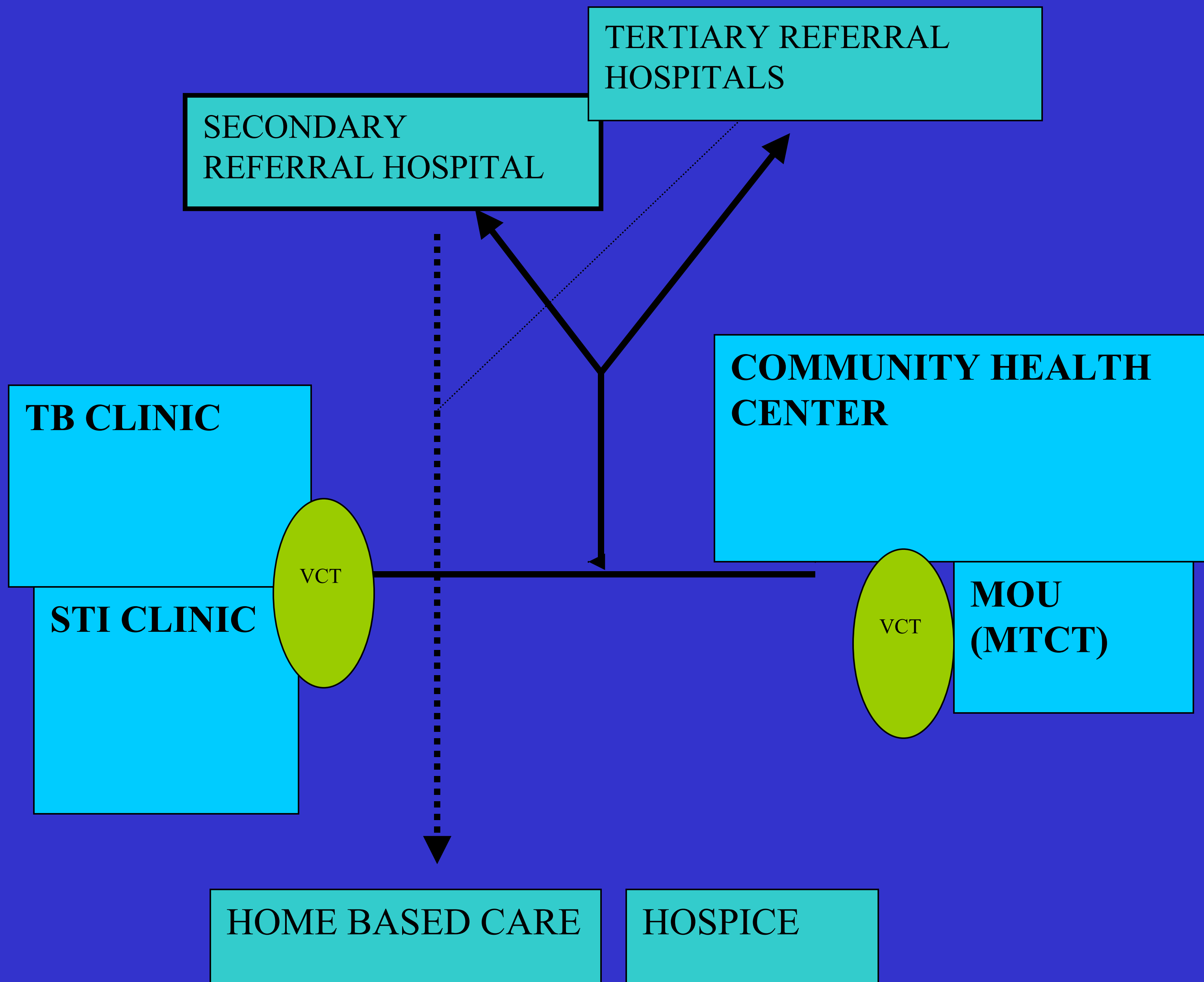
Antiretrovirals

Advocacy

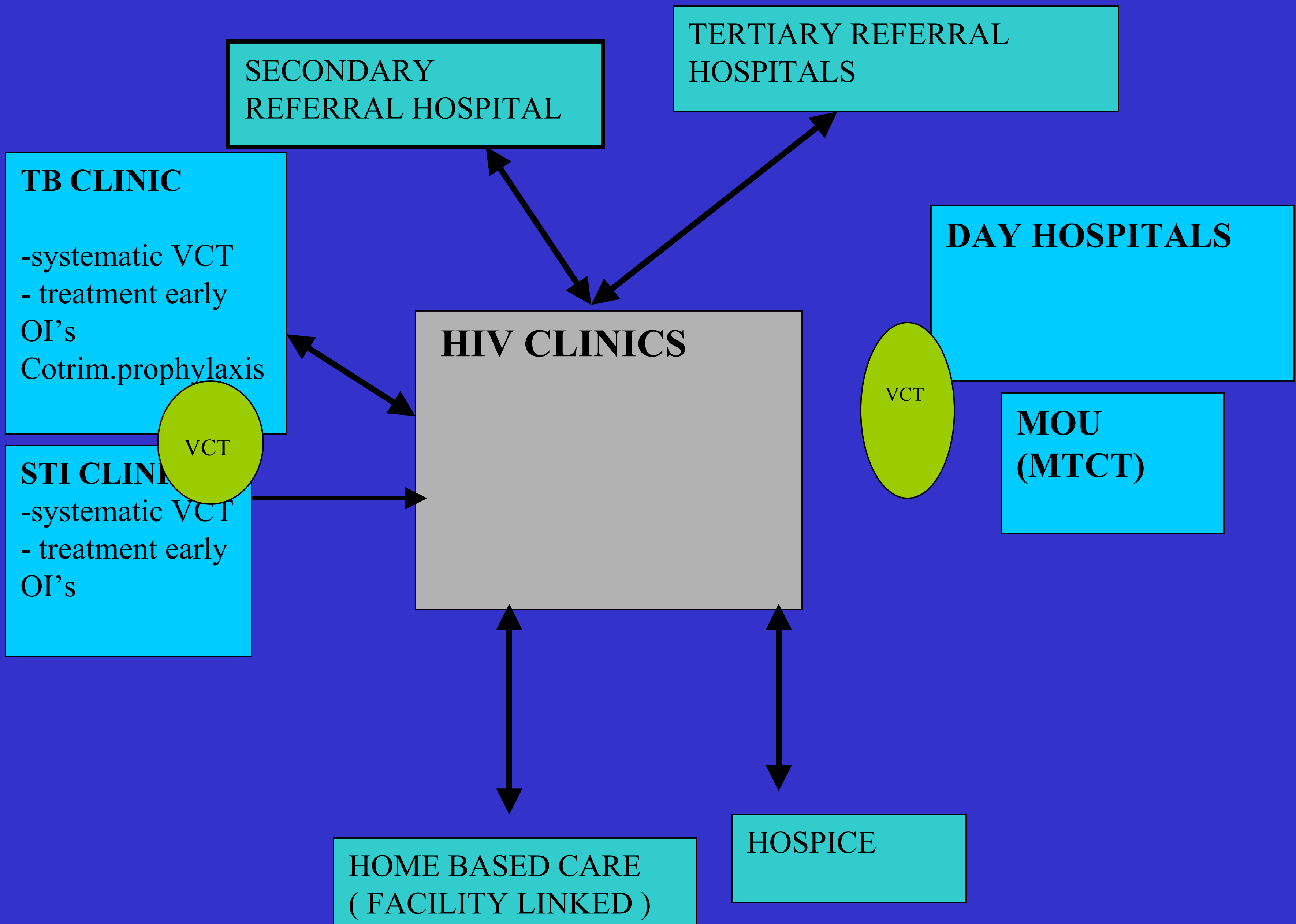


Access to Essential Medicines Campaign

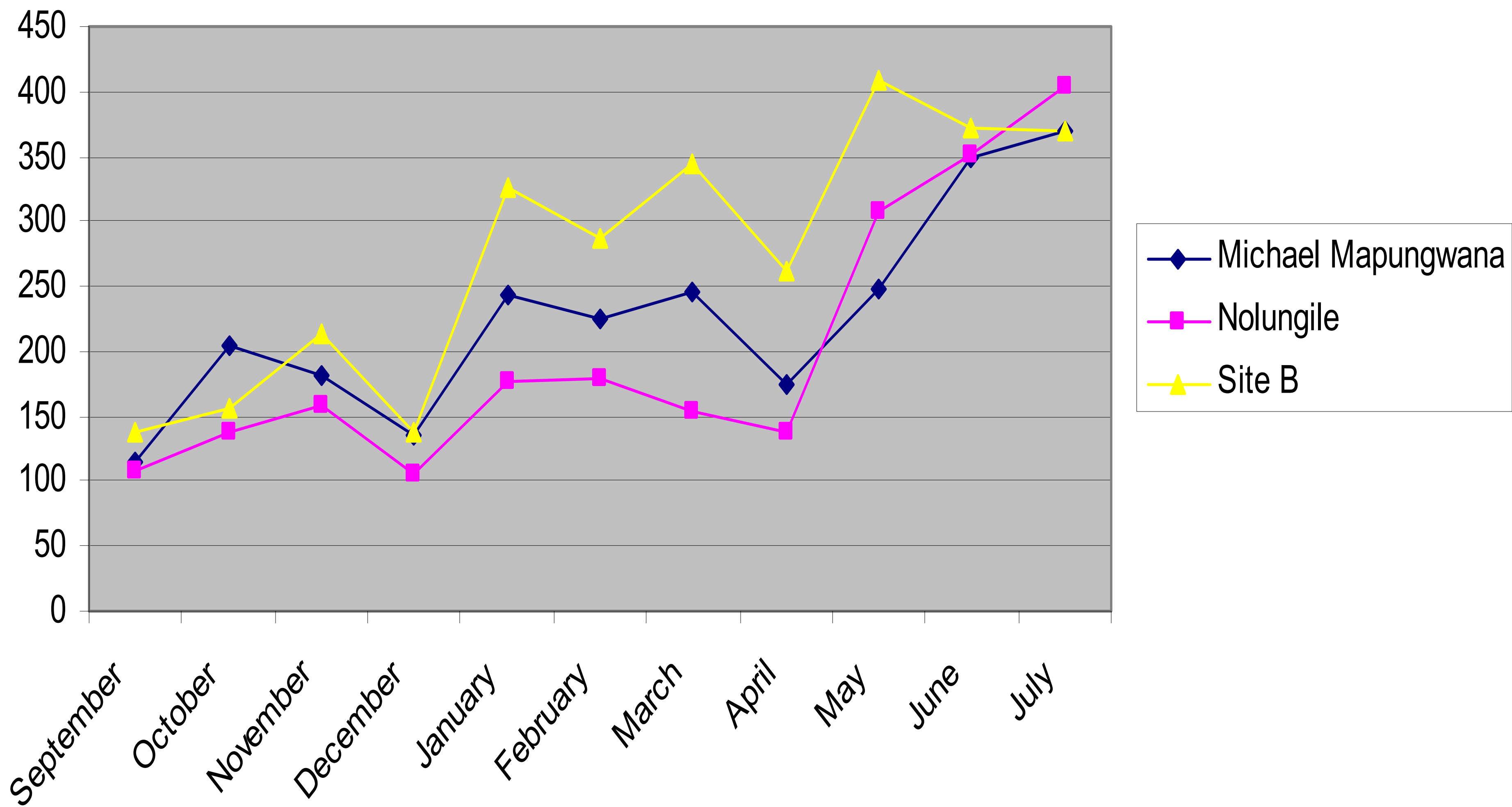
HIV/AIDS care at primary health level (I)



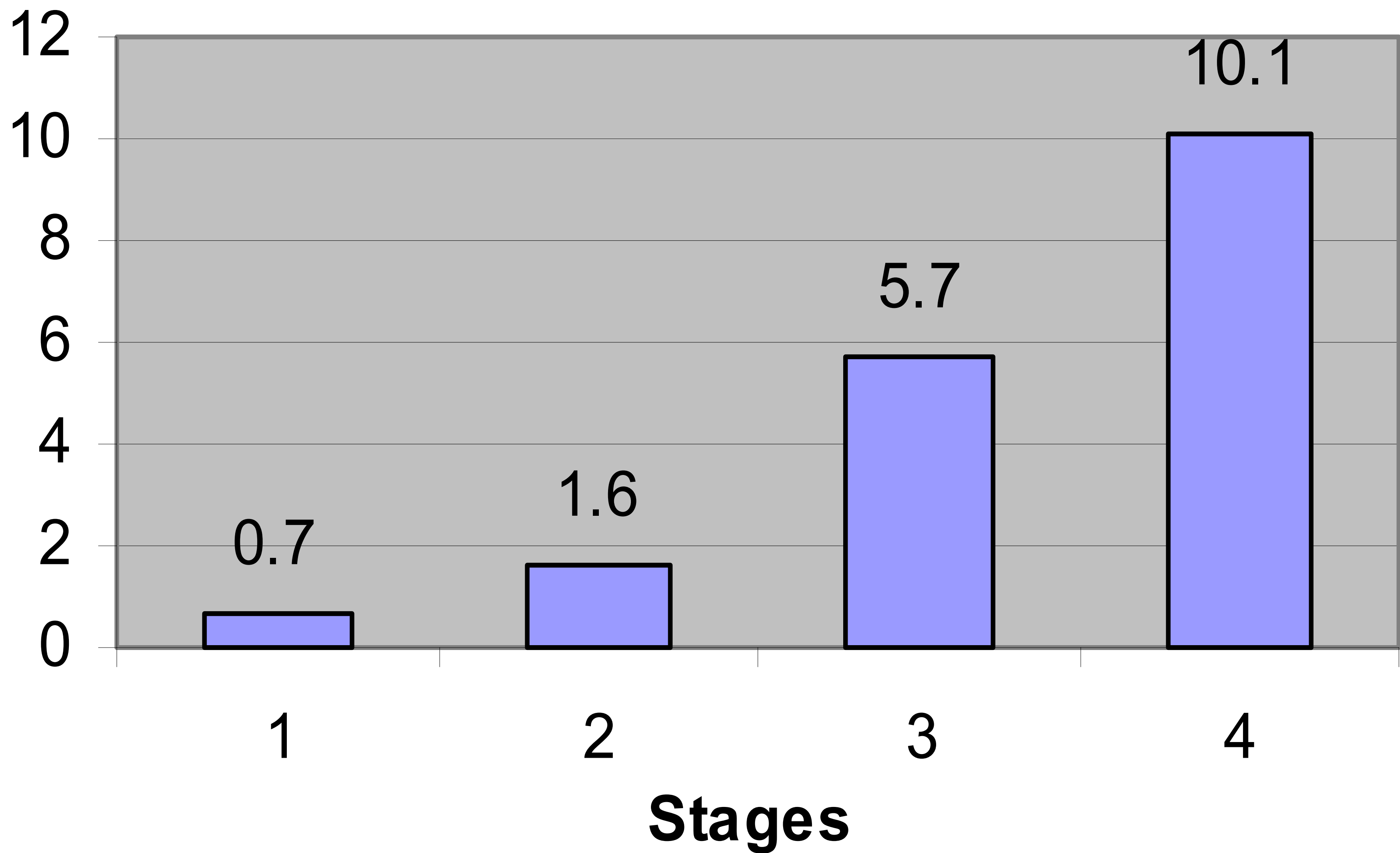
HIV/AIDS care at primary health level (II)



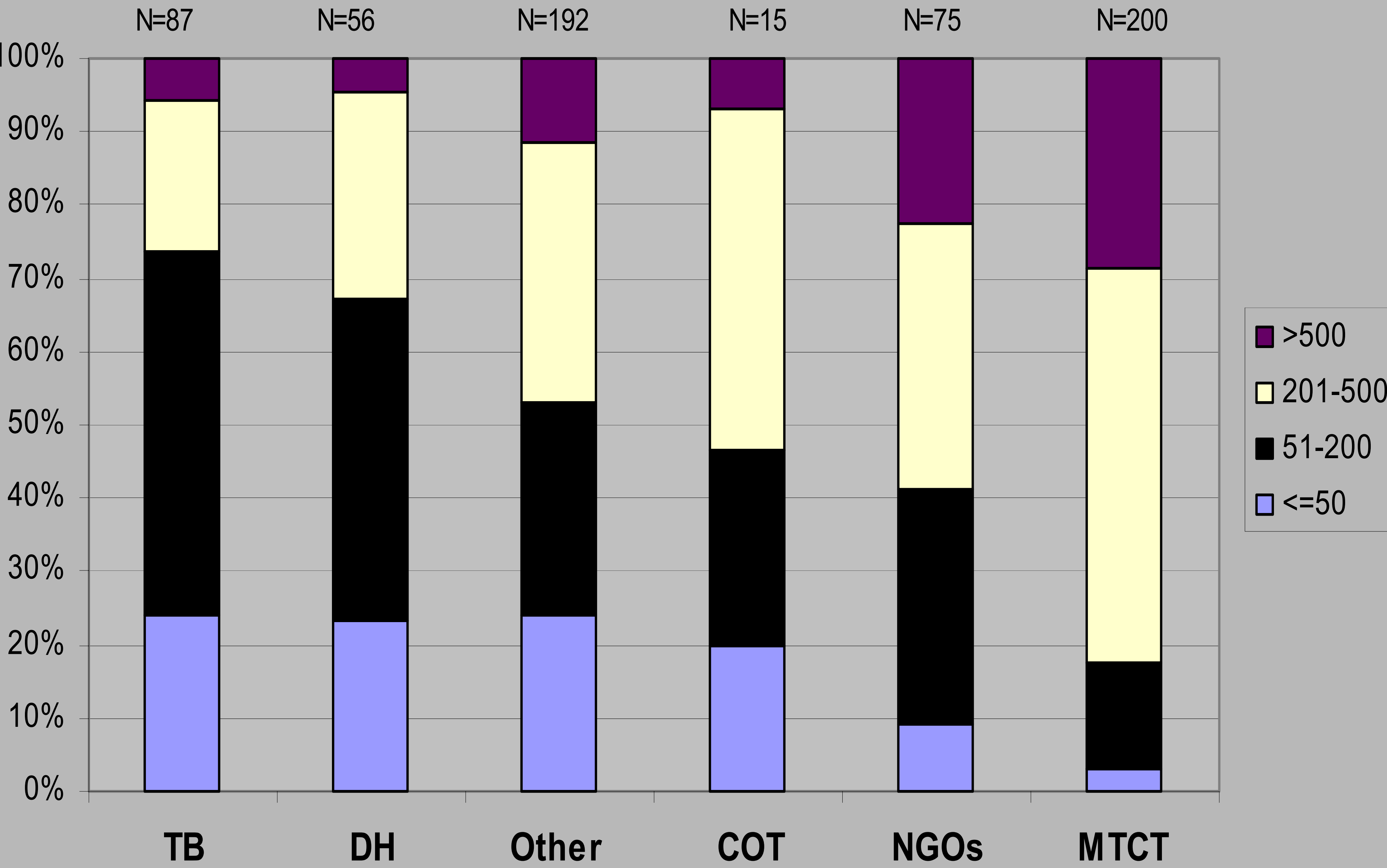
Evolution of total consultations in infectious diseases clinics, Khayelitsha, sept 2000- August 2001



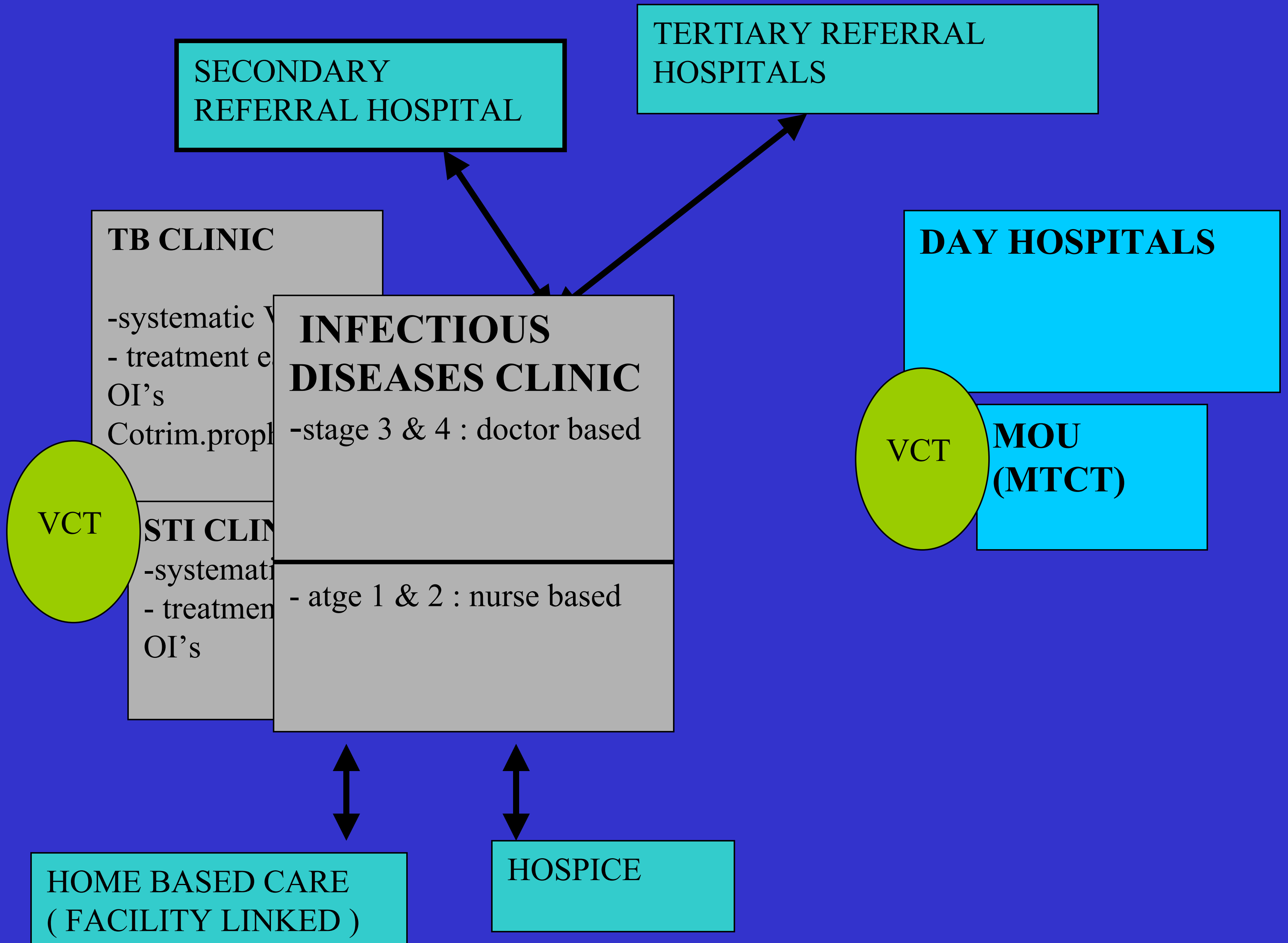
Dedicated service or horizontal approach ?
Number of opportun.infections per patient-year



CD4+ Cell Count by Origin of Patients



HIV/AIDS care at primary health level (III)



Complementary services for ART

- VCT
- Screening for HIV related conditions (TB,STI…)and staging (CD4 monitoring)
- Cotrimoxazole prophylaxis (<200 CD4)
- Treatment of common OI (additional drug supply)
- Nutritional support , psychological and social support
- Peer support groups
- Home based care system
- Lab facility

Complementary services for ART

(not pre-requisite)

- Screening for HIV related conditions (TB,STI…)and staging (CD4 monitoring)
- Cotrimoxazole prophylaxis (<200 CD4)
- Treatment of common OI (complementary drug supply)
- Nutritional support , psychological and social support
- Peer support groups
- Home based care system
- Lab facility

Strategies to minimise risks

- Standardized approach and training of all health staff
- Community endorsement of selection criteria
- Safe and simple regimens
- Community information and individual consent
- Careful lab monitoring
- Alternative regimens if major side-effects develop

Training of health : nurses practitioners oriented

- **Year 1 : HIV related conditions :**
  - » 6 theoretical modules x 3 hrs
  - » 1 year mentorship
- **Year 2 : Basic principles of HAART :**
  - » 8 modules x 3 hrs
  - » Ongoing mentorship and supervision

Antiretroviral therapy
Selection of patients

Patients regularly attending Infectious disease clinics

Pre-selection by clinicians

Patients meeting clinical and biological criteria

Final selection by community selection committee

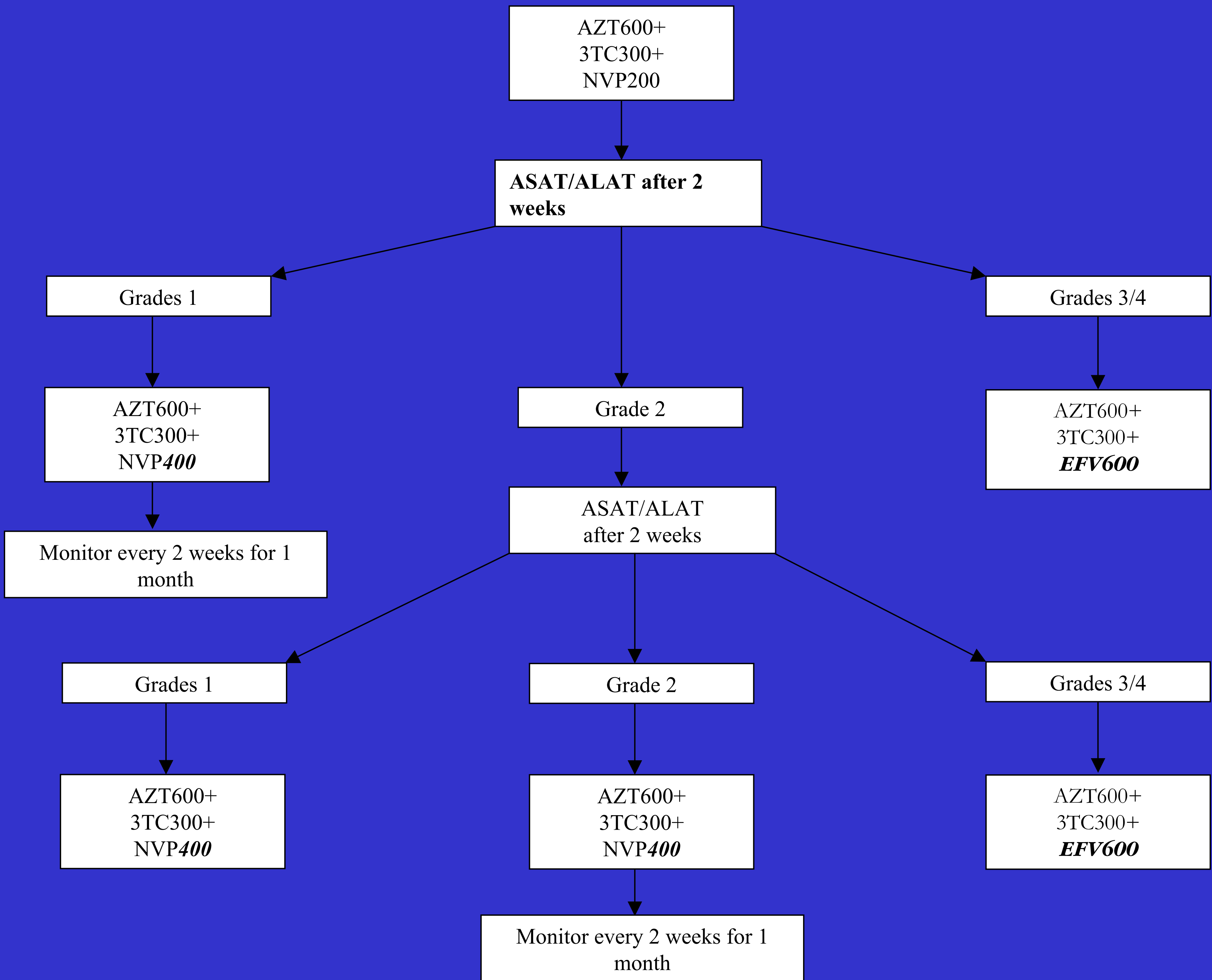
Patients meeting social and adherence criteria

Antiretroviral therapy

- Regimens:

First-line	Second-line	Third-line
AZT/3TC/NVP	d4T/ddI/NFV	ddI/RTV/SQV/ (ABC)

- Standardized approach <-> standardised regimen


AZT600+
3TC300+
NVP200
ASAT/ALAT after 2 weeks
Grades 1
Grade 2
Grades 3/4
AZT600+
3TC300+
NVP400
Monitor every 2 weeks for 1 month
AZT600+
3TC300+
EFV600
ASAT/ALAT after 2 weeks
Grades 1
Grade 2
Grades 3/4
AZT600+
3TC300+
NVP400
AZT600+
3TC300+
NVP400
AZT600+
3TC300+
EFV600
Monitor every 2 weeks for 1 month

ARV lab monitoring

When on first line regimen	**M -0.5**	**M 0**	**M 0.5**	**M 1**	**M 1.5**	**M 2**	**M 3**	**M 6**	**M 12**	**M 18**	**M 24**
FBC+diff	X	-	-	X	-	X	-	X	X	X	X
ALAT/ASAT	X	-	X	X	X	X	-	X	X	X	X
$CD4^+$ T cell count	X	-	-	-	-	-	-	X	X	X	X
HIV RNA	X	-	-	-	-	-	X	X	X	X	X

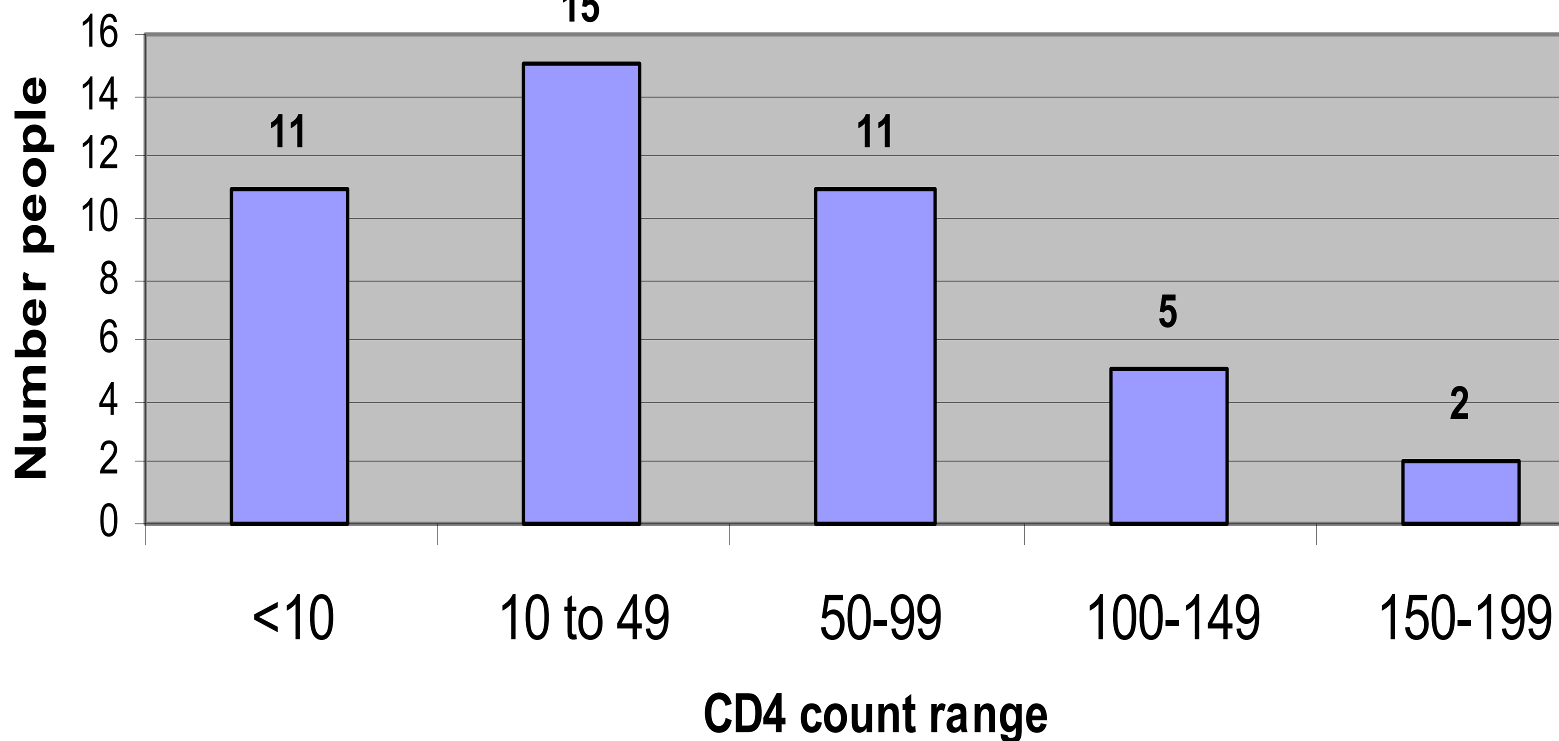
Support to adherence

- Treatment assistant (no DOTS)
- Peer support groups for ART clients
- Ongoing individual counseling (each visit at clinic)
- Adherence materials (pill box, daily schedule, self-monitoring form)

Preliminary results

- 80 candidates selected and 55 had started ART by end September
- Mean age: 34 years
- 70 % women
- 68 % with prior TB
- 3 months viral load : 10/14 undetectable

Baseline CD4 Count for ARV selected candidates



Treatment Literacy, i

- Work focused on four areas:
  - Clients in waiting rooms
  - learners: high schools
  - workers: workplaces
  - general population: use of mass media in Khayelitsha

DONATION PRICE: 50C

equal treatment

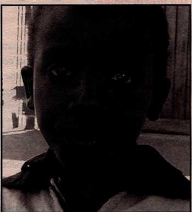
TAC TREATMENT ACTION CAMPAIGN

Newsletter of the Treatment Action Campaign

Vol 3 June 2001

Mother-to-child transmission Prevention

National Mother-to-Child Transmission Prevention Programme Now!



Government can save many lives at an affordable cost. *Over twenty thousand new born infants a year can be prevented from becoming HIV infected through a Mother-to-Child Transmission Prevention (MTCTP) programme. It will cost only R145 million – less than 1% of the 2000/2001 national health budget of R30 billion.*

The death of Xolani Nkosi Johnson is a typical example of what the future of thousands of children will be like. Each year, 60,000 children are, like Nkosi, born with HIV. If their mothers are given Nevaripine or AZT they could be born without HIV and enjoy normal, healthy lives. An MTCTP programme could prevent nearly half of the 60 000 HIV-positive infant infections each year.

So why is government delaying implementing its promised delivery of an MTCTP programme to 18 sites (2 sites per province) country-wide? Instead of bringing this proven, safe, effective and affordable programme to all HIV positive pregnant women, we have been hit with one delay after another. Even implementing MTCTP in these 18 sites is not sufficient, because only 10 out of every 100 (10%) pregnant mothers will be reached by it.

Government promised that this programme would begin in April 2001. Now Minister Tshabalala-Msimang has announced that the whole matter has been referred back to the Cabinet for a decision. The Treatment Action Campaign condemns further delays in implementing the MTCTP programme nationally and has vowed to take whatever steps are necessary to ensure that it is implemented.

TAC has waited patiently for the South African government to fulfil the constitutional rights of every pregnant woman to dignity, reproductive choice and access to health care services. *Reproductive choice* must include the provision of access to programmes to prevent the transmission of HIV from mother-to-child.

The latest surveys of pregnant women attending ante-natal clinics reveal 24 out of every 100 (24%) are infected with HIV. The option of preventing the passing on of HIV to their babies must be available to all HIV positive pregnant women.

This must include:

- Voluntary counseling and testing
- Access to Nevarapine or AZT
- Free formula milk in all areas with access to safe drinking water.
- Advice on breastfeeding for HIV positive mothers where this is not available.
- Proper follow up, monitoring and treatment of mother and infant by a doctor at all times.
- Termination of pregnancy services

With political will government can successfully implement the planned 18 MTCTP sites throughout the country and extend this to a national programme by the end of this year.

There is no justification for any further delay. An MTCTP programme would be cost-effective and, probably, cost-saving. Preventing babies from being infected with HIV is more affordable than treating HIV positive infants. If HIV infections can be prevented our hospitals and clinics would not be so full of sick and suffering children

At a recent TAC National Executive Committee meeting a resolution was taken which mandated the TAC Executive to institute legal action, should it be necessary. We appeal to the government to work with us. If the government takes bold steps to make MTCTP available, TAC will do everything in its power to assist in every way possible.

TAC calls on the Department of Health to immediately announce plans for a national MTCTP programme.

MTCT PREVENTING PROGRAMME:

- Wonke umama ophila nentsolongwane IHIV unelungelo lomntwana ongosulelekanga.
- IMTCTP mayibekho isebenze kuMzantsi Africa uphela.
- Amachiza anjenge Nevaripine angathintela uninzi lomama bangosuleli abantwana babo ngentsolongwane iHIV.
- INevaripine ibhalisiwe yamkeleka ngokuse mthethweni yaye iyasebenza kakhulu.
- IMTCTP mayibekho isetyenziswe ngoku!