RURAL REALITIES

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It is common knowledge that in order to be effective, HIV/AIDS programmes need to include the following components:
- *prevention aspects*
- *care options, and*
- *personal and community support.*

This article addresses some of the issues which impact on attempts by medial professionals to deliver a meaningful level of care to local rural communities.

PREVENTION

Unemployment and resultant poverty in many rural parts of South Africa dictate that most people live from hand to mouth, with their main objectives being to fill empty bellies and ensure a roof over their heads. A desire to learn about a dread disease shrouded with uncertainty and social stigmatisation is near the bottom of their list of basic human needs.

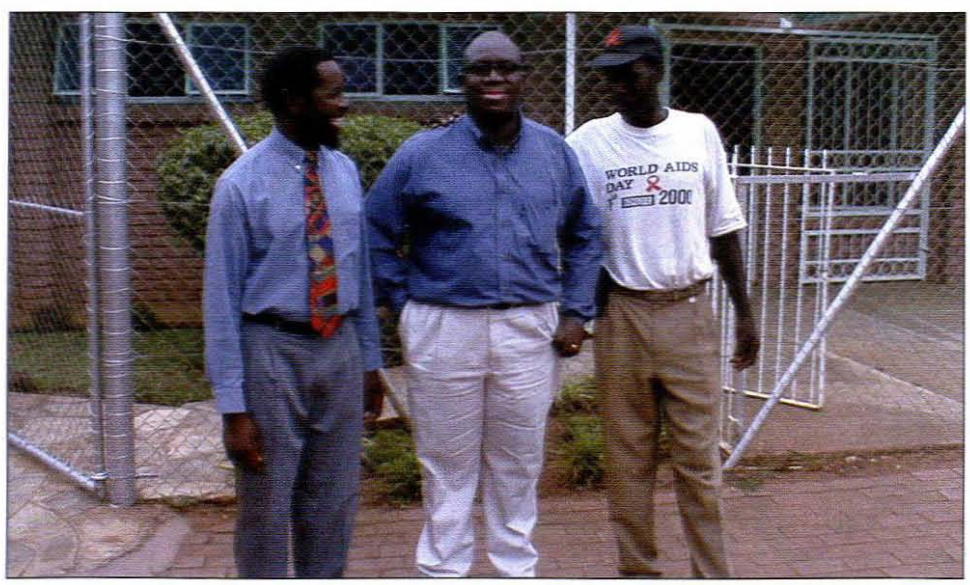
Poverty, together with a high level of illiteracy, results in ignorance, which in turn is compounded by the fact that most educational resources are not easily accessible (clinics/hospitals distance from the community), or in the local language. Community counsellors need to be trained in the vernacular.

Mentorship of these programmes would probably be most successfully organised by local non-government organisations (NGOs) and/or church groups. At present there is a glaring lack of co-ordination or common approach by the main stakeholders – NGOs, government, business, traditional healers and medical practitioners.

CARE

In rural areas far removed from the main cities and towns where public hospitals and clinics have established HIV/AIDS programmes, referral is usually restricted by financial and other constraints, e.g. nowhere for the patient to stay while accessing treatment, absenteeism from work and family responsibilities.

The redeployment of existing health personnel trained in HIV management from the major public medical service providers to heavily populated rural areas (in the manner of China's 'barefoot doctors') would go some way towards alleviating personal and family suffering.



The author (middle) with colleagues.

Inadequate or non-existent laboratory facilities coupled with the high cost of tests (especially CD4 count and viral load) make definitive diagnosis, staging and monitoring of HIV disease difficult if not impossible, particularly in patients with tuberculosis. Even if antiretroviral drugs for the prevention of mother-to-child transmission are available, which mothers would you give the antiretroviral to? The pool of infection simply gets larger.

The majority of rural patients with HIV and AIDS-related conditions are unemployed and can hope to receive at most rudimentary home-based care. Those who are employed are seldom on medical aid, and earn comparatively small wages. This impacts on the extent of provision of even 'cheap' prophylactic treatment for opportunistic infections.

To those rural people living with AIDS (PLWA) who do understand the positive impact of antiretroviral therapy on length and quality of life, it remains an almost unobtainable luxury.

SUPPORT

Despite media interest in foster care and adoption of AIDS orphans, none of these often-reported programmes/activities appear visible and therefore accessible to most rural private practitioners or, for that matter, to families decimated by the virus.

South Africa is a country crying out for skilled workers and in need of such basic facilities as rudimentary home structures, safe running water and home grown-products, but there seems to be no attempt to harness the manpower offered by people living with HIV who are still in good health.

There is a dire need for a system enabling functional networking with national and international organisations to promote rural education, training and funding of projects.

Perhaps research projects focusing on prevalence, subtypes and management options need to be encouraged to include community aspects in their budgets. Drug trials and vaccine development programmes should not be sanctioned unless they include elements of community-based service and social responsibility.

SOLUTIONS

Strategically placed centres for chronic disease management with special emphasis on HIV/AIDS management should be established in rural communities, with initial preference given to those with a high incidence of people living with AIDS.

These centres should be partnerships between government and the private sector. Such institutions could co-ordinate *all* the various activities and programmes taking place in their immediate vicinity – whether privately funded or otherwise, and whether local or international. Related organisations, including those run by religious groups, traditional healers and Treatment Action Campaigners, should be housed together in this hub. This approach should go a long way towards avoiding duplication of services and wastage of finite resources.

Ideally, this kind of centre should offer education, training and counselling for health care and educational professionals as well as interested community members. Awareness and prevention communication campaigns could be run from these centres with a strong emphasis on community outreach projects and social networking.

Laboratory and research facilities could be run and co-ordinated from these local establishments to save on building and transport costs.

The inclusion of social and welfare support programmes, e.g. adoption and foster care services; basic skills training and employment programmes for people living with AIDS and lawyers for human rights, would facilitate access and undoubtedly impact on the community incidence of infection, by becoming the centre of local action against AIDS. A co-ordinated concerted effort, as opposed to numerous fragmented and costly duplications of minor services, would seem to be the best long-term strategic approach.

The multiplicity of the services offered by such a centre would also tend to destigmatise the disease, owing to the enormous role it would play in the lives of rural dwellers.

EXISTING PHYSICAL STRUCTURES

This approach to finding some sort of rural solution to the challenges of the HIV/AIDS pandemic is not about putting up costly new structures – the proverbial re-inventing of the wheel – but about utilising existing facilities, e.g. tribal authorities, church buildings, schools or hospital clinics. The physical structure would simply function as a visible focal point, accessible to the community for co-ordinating of the multiplicity of available services.

There has never before been such a great opportunity for the health care community to commit itself to its responsibility and for humanity to take care of its kind. We miss this opportunity at our own peril.