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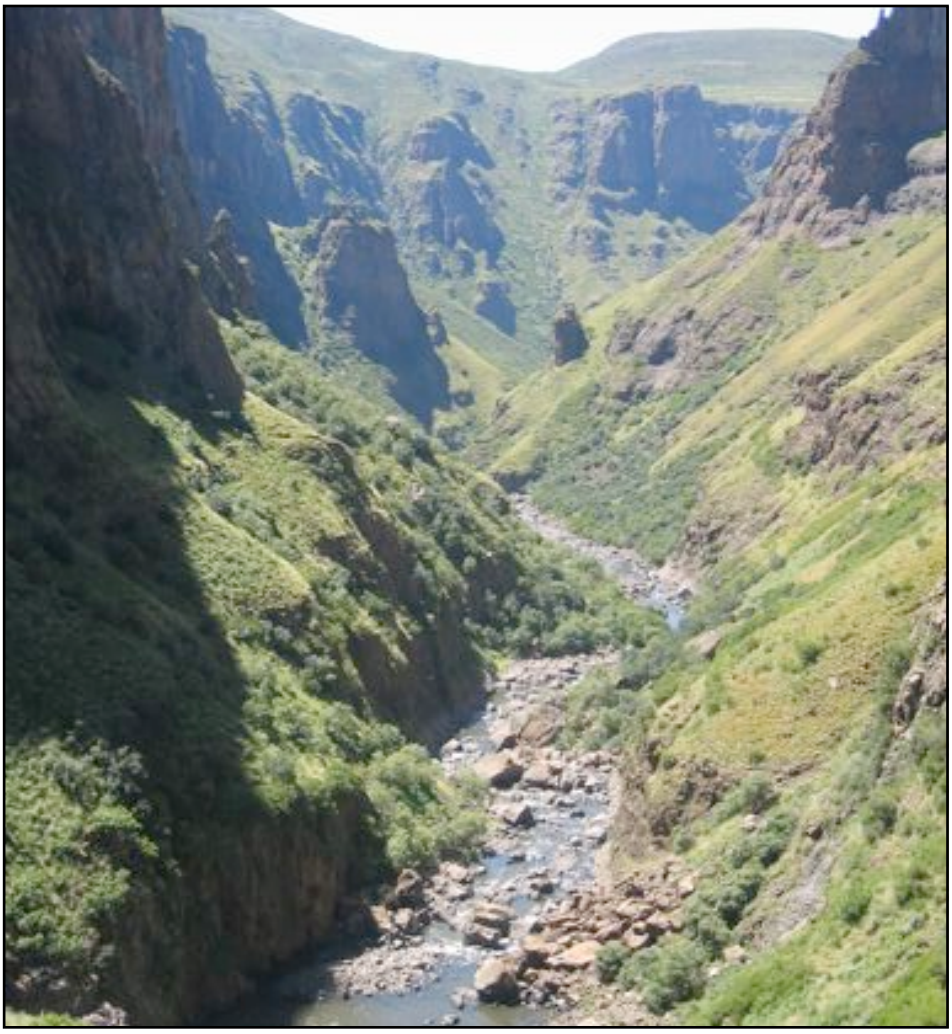

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From the President's Pen

The Lesotho Medical Association, founded in 1973, has to date seen 12,045 days of light. This has been long enough for L.M.A. to evaluate itself with respect to what it has achieved as an Association and whether it is aligned with its constitutional objectives of promoting peace and unity among its members, while instilling in them the spirit of professionalism as they play their part in the vanguard of quality health delivery in our dear nation. How far have we gone and where are we today? We need to conduct a retrospective assessment to identify what our individual contributions have been in the life of this fraternity, what they should be, and what they are going to be in the years to come to ensure that our goals are realized.

The challenges facing health care delivery of Lesotho today are underscored by the stranglehold of the HIV/AIDS pandemic on our society. These challenges call for a re-dedication to our professional duties and extra vigilance on our part as custodians of health in this country. This vigilance demands information and knowledge sharing among us, and the integration and coordination of our efforts and activities as individuals and as an association with those of other health professionals within the patient care team. This cannot happen if we allow our hearts and minds to become enslaved with the demonic powers of animosity and hatred, the canker that devours the souls of associations away and stands in the way of progress in communities. We owe a duty to this nation, which is to ensure that the rights and the health of Basotho are protected. Let us remain united in our actions and pronouncements and be supportive of each other in all we do in order to execute this national duty to the level of perfection society demands of us.

I raise my hat in congratulation to the organizers of The Learning and Sharing Forum for creating a platform for knowledge and information sharing among all cadres of the health profession on health matters, particularly HIV and AIDS. Knowledge is power, so the saying goes and sharing knowledge in matters of concern in health, no doubt, is one of the few strategies we can adopt in our current battle against the many diseases afflicting our nation today. I entreat you to develop the culture of "finding out", the culture of research, which prompts us to learn more about the hydra-headed health problems facing us today. We must empower ourselves with the knowledge we need to solve them to ensure a better tomorrow for this generation and those to come.

I note here with great satisfaction that the Lesotho Medical Association has now become an integral part of the bigger bodies of the African and World Medical Associations. To underscore what unity can achieve, at this point, let us remember that it is with unity that these august bodies have stood the test of time and grown to the level that we can pride ourselves as being part of them. Strength is indeed in unity and in division, we fall.

I salute you all in the name of the Almighty God. He knows what we don't know and he prepares us adequately for the unknown.

God Bless you.

DR C.K. HOEDOAFIA

Editors

Instructions for Authors

The Lesotho Medical Association Journal accepts editorials, original research papers, review papers, case discussions, clinical guidelines, letters or Lesotho medical news reviews.

The author should submit both an electronic and hard copy of the manuscript to the address below:

Lesotho Medical Association Journal
Dr. Musi Mokete
P.O. Box 588
Maseru 100
musi@lesoff.co.za

Editorial: Senkatana Clinical Project

The Senkatana clinic has been a pioneering success in administering antiretroviral therapy. It serves as a model and is stimulating the subsequent establishment of many other clinics throughout Lesotho. Credit for the establishment of the project goes to Bristol Myers' initiative enhanced by the tripartite arrangement including the Lesotho Government, which has generously, provided the infrastructure and secondment of some staff members, and the Lesotho Medical Association (LMA), which was charged with recruitment and supervision of staff.

The L.M.A.'s involvement presented the incumbent Executive Committees with quite a challenge including:

(1) Capacity building of the L.M.A. itself (establishing and equipping the office as well as paying the secretary). We acquired buildings for the office as well as rentable outbuildings for sustainability. For this capacity building, we thank Bristol Myers immensely.

(2) Resuscitating our medical journal, which has carried the messages of HIV / AIDS for our colleagues and other interested persons. Our gratitude goes to Bristol-Myers. We have also had outreach, through district-level discussions with other colleagues. The above gestures are rare innovations, which should be replicated elsewhere as part of smart partnership.

It would be remiss of me not to mention a very difficult task right at the beginning, which was to recruit and screen staff for Senkatana clinic, which has in fact made Senkatana effective and efficient in carrying out the mission of securing the future. We are happy with our choice of staff from the beginning and throughout the running of the project.

We may have not been very regular at Senkatana review meetings because of our part-time basis there and our various commitments, but Senkatana with its own expected problems, has matured with contributions from all stakeholders.

We are aware that the project is ending per schedule, however, we hope there will be some new modus operandi which, for the sake of the clients, will make Senkatana clinic to live long in a sustainable way.

For any new initiatives, the Lesotho Medical Association is still very much prepared to cooperate. We have learned a lot too and are prepared to share information and experience for the sake of us all. Long live Bristol Myers, Government of Lesotho and L.M.A. - Senkatana initiative!

- Dr. 'Musi Mokete

Editor's Note: Another Shot in the Arm

The help from Bristol Myers Squibb for printing our journal has hardly expired and we have gotten another shot in the arm from Boston. The help, which we greatly appreciate, will be in the form of comprehensive printing and modernizing the journal. We hope the L.M.A journal will be more attractive for the readership. There is no doubt that our printing skills and networking will also be enhanced in time.

We are looking forward to a fruitful working relationship. Thanks to the Lesotho-Boston Health Alliance and the Kellogg Foundation for their assistance.

Dr. 'Musi Mokete
Editor, Lesotho Medical Journal

Forty Years of Health Services Development in Lesotho: Successes, Failures & Challenges

'MUSI MOKETE, MD

INTRODUCTION

In 1966, Lesotho's doctor/patient ratio was still very low with 1 doctor to 14,000 patients. The number of hospitals is the same as it was then except that satellite clinics have increased in number. Most of the Graduate Doctors came from: WITS (11) (Makenete, Ntšekhe Mphahlele, Makotoko, Mahabane, Cindi, Ntšekhe, Tlale, Maema, Lebona, Nkuebe), Glasgow (2) (Mokose), Edingburgh (1) (Hoohlo), University of Natal (7) (Maitin, Mohapeloa, Molotjwa, Molapo, Letsunyane, Matthews, Phakisi), and India (2) (Qhobela, Nthlakana).

Specialists were few and included Dr M.V. Ntšekhe in Psychiatry and Dr Mphahlele obstetrics and gynecology.

Many nurses had qualified in R.S.A. then and the only available specialization was theatre nurse specialists. Doctors and Nurses still had to endure the hardships of conditions in Mokhotlong and Qachas Nek and Quthing to some extent, which were reached by airplanes. Among their complaints were insurances for their on-the-job risk.

The Flying Doctor service had been started by Dr Carl Van AsWegen a private medical practitioner who used his own plane from 1957, but later handed over the mammoth task of flying and curing patients in the mountainous areas to the Government of Lesotho.

1966-1980

The period between 1966-1970 had lots of difficulties in specialized treatment for citizens of Lesotho.

By 1967, Van Graan, from R.S.A. on Secondment with the L.N.D.C. establishment, agreed with the late Anton Rupert (tobacco Magnate) to establish a shuttle service which would be paid for by Anton for all the technical experts and their boarding and lodging. The shuttle service was launched with orthopaedic surgeons, gynecologists, dermatologists, ear nose and throat specialists, anesthetists and theatre nurses in 1968. They came on a monthly or quarterly basis, depending on the cases referred from different hospitals and private settings in the country. They also delivered some lectures by arrangement with the Medical Association on each visit. Theirs was a praiseworthy task, but it was not sustainable. The Mission was closed in 1978.

The coup de etat in the 70's disrupted many programmes, including health development because most of them were on an ad hoc crisis response basis. Many graduates from outside traditional medical schools (e.g. eastern countries) for which Government and Medical Council were not ready to accommodate within the system thus resulted in prolonged housemanship (internships) and acrimony. Nigeria had taken two medical students into Lagos in 1970.

At a commonwealth regional conference held in Botswana in 1972, the countries of Uganda, Zambia, Kenya and the Ibadan Medical School agreed to help Lesotho, Swaziland, Malawi and Botswana through a quota system for accepting students to medical school. Uganda and Zambia took two students, and Kenya, Nigeria and Ibadan each took one student. The two students in Uganda later transferred to Kenya during the Idi Amin crisis.

1974 USHERED IN A FEW BUMPS

1. The shuttle team (Anton Ruperts) offered training for 4 medical students who would eventually specialize and come home to sustain services. These four had some difficulties including political clearance, but sufficient indirect pressure was brought to bear on the Ministry of Health to let them go. By some luck the Afgrad (Canadian) Scholarship Programme became available at the same time, and the candidates opted for it and studied in Canada. A year later they were brought to Nairobi to continue with medical studies and one remained in Canada.

2. More specialized nurses were trained for pediatrics, theatre, and orthopedics

3. Following the contact with the South African Institute of Medical Research we scraped training in Natal for Pap smear and Histology for one technician.

4. Orthopaedic technicians were trained in Brazil so they could take care of prosthesis and prosthetic requirements following orthopaedic work.

5. An Eye Ward was established by the Israeli Government in collaboration with the Lesotho Government. An eye doctor and nurses were trained in 1975.

6. One more opportunity was squeezed in to train a medical practitioner in Lagos, Nigeria.

7. W.H.O. provided two technologists who were British and Jamaican.

8. Realizing that there was a crisis in producing doctors, a feasibility study was outlined for a medical school because at that time, according to W.H.O. one million people were worth a medical school. On behalf of W.H.O., one feasibility study was conducted by the Dean of Hebrew University Medical School, another by the Dean of the Medical School in Natal and establishment was done by an Argentinean employed by W.H.O.. Farar. U.N. report reinforced the project after the Matanzima Qacha's nek blockade. The calculation was that Lesotho would have 20 students initially and that the other students would come from Botswana, Swaziland and the discriminated black students from South Africa. As apartheid was at its harshest periods then, South Africa would help offset the costs with international help.

After the Alma Ata conference with a theme "Health For All In Year 2000" Lesotho Government in 1978 assisted by W.H.O. and U.N.D.P. sent a delegation of four to Nigeria (IFE) University and Yaunde University in Cameroon to study whether a medical school without mortar and brick expenses would survive in a developing country. In short this was proven and reported back as those medical schools then were using existing structures modified for the purpose and were successful. The mission even took it upon itself to be proactive and the request for ten places in each of the universities for premedical studies as Lesotho was not yet ready with facilities then. Those were granted, but the Lesotho Government was only able to send four candidates to IFE who were offered scholarships by their respective governments.

The Alma Ata Conference caused the government to pay attention to Primary Health Care, which was not given attention hitherto. In the past 26 years, this strategy has made impressive gains in the improvement of the health status of Basotho, particularly in the reduction of mortality amongst the under five age group. The Expanded Programme for Immunization and the Programme on the control of Diarrhoeal Diseases (CDD) can be singled out for having had a significant impact.

A Nurse Clinician Programme was started in 1975 through USAID help picking up on the successful Jamaican Programme. These were experienced nurses who were trained for 18 months to serve as a bridge between the doctor and staff nurses in terms of function and responsibility. It did well whilst it received support.

Meanwhile a Faculty of Health Sciences had been established at the National University of Lesotho, and the first two-year diploma course in Pharmacy was sponsored by the German Government. Preparations for the University (books for the library, microscopes, staff etc) were in progress until the Government aborted the project in 1983 due to reasons of expense. It is interesting to note that the project had been well researched through conducting feasibility studies under that political climate.

OTHER HIGHLIGHTS OF THE SEVENTIES

a. Lesotho Pharmaceutical Corporation and NDSO were established in 1972 to manufacture and distribute drugs in Lesotho and out of the country. Initially this was a very successful project having sales even in Zimbabwe, Mozambique, Malawi, Uganda and Transkei.

b. Private Health Association later Christian Health Association of Lesotho was born in 1974 after the 1972 WHO Lesotho delegation bought the idea from Malawi Private Health Association. This step radically changed services in Lesotho resulting in more cooperation between mission health services (hospital and clinics) and the Government. There was a fair distribution of services irrespective of religious denominations and geographical establishments. Common buying form LPC was also entrenched.

c. Around the same time the Lesotho Delegation to WHO's Annual General Meeting, clinched an agreement with Medicus Mundi (a Dutch and German Health Services organization which is part voluntary), which provided doctors (General Practitioners, Paediatrians, Gynaecologists) local salaries paid for by Lesotho's Government. They worked in Qachas` nek, Quthing, Mafeteng, Mokhotlong and QEII Hospitals. Some also worked in some mission hospitals such as the Morija Scott Hospital. This partnership lasted from 1974 until 1978 with no sustainable, strategic programme.

d. Many Basotho Doctors resigned for Private Practice during that time because of low salaries and bad working conditions.

e. A Nurse Anesthetist Programme was accepted by training four nurses in Mozambique in 1979 due to be followed up in the late eighties.

1980-1990

1. The demise of the Health Services faculty Programme due to the Government's decision was already referred to earlier.

2. An E.N.T. Department was established in 1982, headed by a Ugandan doctor until 1987.

3. Lesotho topped many countries in the developing world with its 80% achievement in the Extended Programme of Immunisation.

4. N.H.T.C. (National Health Training College) was established in 1988 as the nursing school was restructure. The college trained public health practitioners, nurse clinicians, and also provided diplomas in nursing and midwifery, mental health, nurse anesthesiology, and an ophthalmic and a pharmacy technician programme.

5. Many public health medical practitioners were also trained in the eighties: 2 in Israel and 3 in the United States.

6. Towards the latter half of the eighties South Africa opened the doors to their medical schools. In the 90`s, Lesotho had its two specialists in gynecology and obstetrics trained in Zimbabwe. There was also a surgeon trained in Edinburg, another trained in Glasgow, and a pediatician trained in South Africa.

1980-1990

1. More doctors qualified, but did not come back because of the lack of inducement and improvement in

the conditions in Lesotho as well as the lack of follow-up of the Southern African Economic Development Community (SADEC). Also, the Commonwealth decision that sister countries should not poach from each other was not upheld and the migration of doctors to R.S.A. in particular has greatly affected the brain drain in Lesotho.

2. Through funding from the African Development Bank, all government hospitals in the country were given a tremendous face-lift, except QEII. The Mission Hospitals were to be included in this in 1996, contingent on Government's approval. Due to a delay in the approval, the scheme was aborted.

3. A Temporary Memorandum of Understanding between Government and mission Hospitals was signed. In CHAL institutions, doctors' and senior nursing staff's salaries were paid for by the Government. Preparations are now afoot for long-term support after legal logistics have been agreed upon.

MAJOR ACHIEVEMENTS DURING 2000-2006

The Ministry reviewed its policy in 2003 to address new developments and the declining health indicators. A corresponding strategic plan outlined strategies to improve access to quality health and social welfare services. Achievements to date include:

1. Strengthening Partnership and Partner Coordination

In recognition of the positive contributions by the private sector, stronger ties were established between private providers and the Ministry, as well as between donors and the Ministry. These were negotiated through a joint MOU. Through this arrangement, citizens are able to obtain subsidized services at GOL, CHAL facilities and some private surgeries.

2. Strengthening Human Resource Development and Management

The doctor/population ratio has remained one doctor for 14,000 – 16,000 people, but new developments like HIV/AIDS, attrition etc, requires more manpower. In response a policy decision was taken to develop new auxiliary cadres to absorb the extra work brought about the emergency of HIV and AIDS. Two new schools of nursing were opened and the Faculty of Health Sciences at N.U.L was opened. Strategic Plan for HR development and management was developed and implementation is ongoing.

3. Scaling up HIV/AIDS Prevention, Care and Support.

A new directorate to oversee the implementation of HIV and AIDS control was established in 2004. Since then, prevention and care interventions have been stepped up. HIV prevalence however remains high at 23%. However the Ministry introduced ARV for eligible patients at public and private outlets free of cost. About 12,800 PLWA were on ARV by September 2006. A Pediatric Centre of Excellence for Children with HIV and AIDS was established in Maseru in 2005.

4. Improvement of Health Infrastructure

The Ministry has started the process of replacing QEII Hospital through a PPP arrangement to be completed by 2009. Through similar arrangements the Ministry HQ is currently under construction and expected to be complete in 2007.

Negotiations are ongoing to rehabilitate both GOL and CHAL health facilities through a grant from the Millennium Challenge Corporation (MMC) - US Government. The Mohlomi Mental Hospital and NHTC are also being upgraded to provide for more patients and students respectively.

CHALLENGES

1. The HIV/AIDS epidemic has challenged the country since 1986 and is now at a high level of priority for the Government now, although it was slow to respond initially. There has been extensive HIV/AIDS education. It continues at all levels and ARVs

are being rolled out. Many sympathizers, philanthropists, universities have come up in numbers to stem the ravages of HIV/AIDS. These groups need coordination and the Government must have a strategic plan of filling the gaps when they leave.

2. The brain drain must be stopped. Retention has to be practically implemented. Conditions for service have to be improved, including strengthening continuing medical education to produce more expertise.

3. A new referral hospital has been on the table since the early seventies. This is a priority and with good staffing, the flow of money out of Lesotho to RSA can be kept under control.

4. Managing the shortage of doctors has only seen short-term solutions thus far. In the 1970's batches of Korean Doctors were recruited to Lesotho and in 1973, Egyptian Doctors arrived. In the years to follow, we have seen, Chinese and Cuban doctors all trying to fill the gap, but with no specific contribution for the long-term development of the country. Counterpart training is absolutely essential. A plain for strategic development has to be firmly in place, with priorities well laid out.

5. Purchase of laser machines for diabetic retinopathies should be included in the priority list before 2007.

6. Maximum effort must be made to re-engag all the Basotho medical professional who have left the country.

HIGHLIGHTS

1. The past L.M.A executive member and treasurer Dr Mphu Ramatlapeng is the new Minister of Health and Social Welfare (2007) Good luck, Honorable minister!!!

2. The past President of L.M.A, Dr. Makase Nyaphisi, has become the new Lesotho Ambassador to the Federal Republic of Germany – Congratulations your Excellency!!!

3. Dr Peerbai, is representing Lesotho as an Ambassador to India. Well done your Excellency L.M.A is proud of you and your wife. Bravo!!

4. Hopefully, Dr Motloheloa Phooko, the former minister of Health and Social Welfare, now a minister to the Prime minister will be helpful in adding a voice to the ex- LMA executive chorus.

5. The following hospitals are celebrating anniversaries in 2007:

- Morija Scott Hospital is 70 years old.
- Paray Hospital in Thaba-Tseka is also celebrating its 70th Anniversary
- Motebang Hospital in Leribe is 100 years old.
- Quthing Hospital will be 99 years old.
- Mafeteng Hospital is celebrating its 98th Anniversary
- Mohale's Hoek is celebrating 97 years of service this year.

Developing a Family Medicine Residency Programme in Lesotho: Training Physicians for the Future - The Time Has Come!

BRIAN JACK, MD[1]
HONOURABLE MINISTER MOTLOHELOA W. PHOOKO, MD[2]

[1] *Boston University School of Medicine, Department of Family Medicine*
[2] *Government of Lesotho, Prime Minister's Office*

INTRODUCTION

The Ministry of Health and Social Welfare of the Government of Lesotho, in partnership with Boston University and the University of the Free State, is planning to initiate a new postgraduate training Programme (i.e., training after medical school) in Lesotho for physicians that will prepare them as specialists in family medicine (FM). Organising a family medicine residency programme is a central step In developing a long-term, sustainable system of care at the district hospital level. Over the four years of continuous training, these physicians will learn the essential knowledge and skills needed to practice effectively at the district level in Lesotho. This new Programme will include training in the essential areas of medicine (internal medicine, pediatrics, obstetrics and gynecolgy and surgery) and, in addition, will provide substantive training in public health and management so that they will be prepared to assume leadership positions in clinical medicine and management at the district hospitals. We believe that a high-quality training Programme will draw home for training some young Basotho who are currently training outside the country and, after training, many of the trainees will decide to remain in their homeland. The net effects will be to increase the number of physicians in the country who know the culture and customs of the country, are well-trained, and are highly motivated to improve the conditions of the national health system.

Although the training proposed will be tailored to the specific needs of the people of Lesotho, the Programme curriculum and the certifications will be in the specialty of family medicine. The purpose of this article is to introduce this new Programme to the Lesotho medical community and to provide information about the specialty of family medicine as it is practiced around the world.

EVOLUTION OF FAMILY MEDICINE

In the mid-twentieth century, the prevailing belief in many countries in the ability of science of science and technology to solve medical needs resulted in increasing reliance on medical technology and more emphasis on training specialist physicians. These trends ultimately resulted in a maldistrbution of medical personnel characterizes by too few primary care providers and too many specialist. This led to a fragmentation of health care provision, depersonalization of the health care experience, worsening health outcomes, over-reliance on technology and escalating costs. As a result, the maturation of a new generalist specialty has occurred in many countries around the world. The principles that have come to characterize family medicine (also known as general practice in some countries) throughout the world are shown in Table 1.

Table 1. Key Concepts in Family Practice

Contact: The Family doctor is the physician of first contact. Family doctors are specialist in caring for undifferentiated problems.

Contactable: Family doctors are accessible to individuals and to the community

Comprehensive: Family doctors practice includes prevention, health education, diagnosis, treatment, rehabilitation, and the management f acute and chronic illnesses.

Continuity: Family doctors are involved in many of life's important events. Trust is developed over time. Care is improved through knowing families and their medical history.

Coordination: Family doctors are the web of the health care system. Family doctors are advocates for their patients for their patients and help their patients negotiate the system.

Cost Effective: All of the above lead to the best match of needs and resources.

EVIDENCE FOR FAMILY MEDICINE

There is increasing global recognition of the value of this approach.[1] Studies have shown that a strong primary care component to the national health system is associated with lower risks of hospitalization, shorter lengths of stay in the hospital, and decreased costs. A country's level of primary care is closely related to improved national health indicators including patient satisfaction, more appropriate medication usage, and better health outcomes including improved rates for infant mortality, life expectancy, and years lost. Studies have demonstrated that a primary care-based health system (as compares to a specialist-based system) will reduce costs while maintaining quality. The points listed below are drawn from studies around the world that were done in industrialized countries and compare the level of primary care in a country to the level of specialty care. They are presented to provide a sense of the data available showing the importance of the relationship between the levels of primary care development in a country and the outcomes obtained from a national health system:

- In England, each additional primary care physician (PCP) per 10,000 (about a 20% increase) is associated with a decrease in premature mortality of about 5%, adjusting for long-term illness and demographic and socioeconomic characteristics.[2] In the United States, the effect is greatest if the increase is in family physicians. One more family physician per 10,000 people (estimated 33% increase) is associated with 70 fever deaths (estimated 9% decrease) per 100,000[3]
- The greater the supply of primary care physicians, the lower the infant mortality and low birth weight percentages. An increase of one PCP/10,000 is associated with a 2.5% reductions in infant mortality and a 3.2% reduction in low birth weight.[4]
- The greater the supply of primary care physicians, the total mortality from heart disease and stroke at the US country level decreases.[5]
- Each increase in primary care MD supply is associated with a higher odds of early stage diagnosis for colorectal cancer and melanoma.[6,7.,8]
- Adults (>25 years) with a primary care physician rather than a specialist as their personal physician had 33% lower cost of care and were 19% less likely to die prematurely (after controlling for major confounders).[9]
- Each one-third increase in the supply of family physicians decreases the incidence of invasive cervical cancer by 10% and the mortality from cervical cancer by 20 %. There is no effect of non-primary care physicians.[10]

In sum, there is clear evidence that building a health system that has a strong emphasis on primary care makes a great deal of sense. This is especially true in countries like Lesotho where resources are limited.

The role of FM in the achievement of quality, cost-effectiveness and equity in health care systems was affirmed by WHO in 1994. The WHO emphasized its commitment to reorienting medical education and practice toward generalism in 1995 resolution stating that orientation of the health system toward primary health care is listed as one of six fundamental principles that could improve health care systems. The WHO recently articulated a global strategy fro changing medical education and medical practice for health for all emphasizing the role and education of generalists. These "five star doctors" have skills that are essential everywhere.

FAMILY MEDICINE IN LESOTHO

We believe that there is strong evidence that the foundation of the health care system in Lesotho should be based on the family medicine model of training. This is not, of course, to say that specialists are not important in Lesotho – it is critical that there be a balance between primary care and specialist physicians. Our position is that at this point in the development of the health system in Lesotho that a broad training Programme in family medicine is the best next step forward, rather than investing limited funds in the training of specialists.

The curriculum developed for the new training Programme in Lesotho will be based on international standards but will be adapted to meet special needs of the people of Lesotho. This means that the training Programme will emphasize those skills needed to function effectively as a district doctor including an emphasis on surgical and orthopaedic skills, stabilization and initial treatment of the trauma patient, obstetric surgery, and care of HIV / AIDS. Ambulatory care skills in the areas of prevention, care of chronic disease, care of communicable diseases, and wide range of hospital kills for children and adults will also be emphasized in the training.

Starting a high-quality training Programme in Lesotho will begin to draw home some of the young men and women who are currently in training outside the country, but convincing them to stay once their training is completed will also be addressed. The Programme will therefore also contain physician retention strategies that will focus on improving the functioning of the district hospital so that there is an improved practice environment that will allow the newly trained physicians to use the skills they learned and will identify financial and lifestyle mechanisms that could be used to provide incentives for these new, well-trained physicians to remain in the country. Thus, improvements in the financial and operational management (and, where necessary, linkage to health policy reforms) must go hand-in-hand with clinical training for this Programme to be successful.

Planning for this Programme is now actively underway. There will be oversight by an advisory board that will be made up of key representatives from the Ministry of Health and senior physicians from Lesotho. The plan is to begin training six residents each for three years beginning in January 2008. Current plans are for training to occur at three sites (1) Maluti Adventist Hospital, (2) Motebang Hospital in Leribe and (3) Berea Hospital in TY. Teaching will be done by 3-4 full-time faculty members who will organise that Programme and be fully active in patient care. Initially they will be experienced faculty brought in from outside of the country, but these positions will be transitioned to local faculty within three to four years. In addition, there will be short-term teaching by both family medicine and specialty faculty from Boston University of the Free State who will provide on-site consultations and resident teaching. These faculty members will also be called upon to provide continuing medical education for physicians in practice. Continuing nursing education will be linked to the National University of Lesotho and the National Health Training College and emphasis will be placed on developing the collegiality and co-training needed to build well-functioning district medical teams that include nurses, hospital administrators, pharma-

cists, anaesthetists, laboratory technicians, community health centre staff, and others.

FINAL COMMENT

Lesotho has made a remarkably impressive response to the challenges brought on by HIV/AIDS. Starting a family medicine training Programme within Lesotho can build upon these initial successes and is an important next step in building a strong health sector infrastructure to assure sustainable health services of good quality for the future.

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HIV/AIDS and Mental Health

DR. S.P. SHAIKH[1]

[1] *Mohlomi Hospital*

HIV/AIDS: THE CURRENT SCENARIO

Worldwide

- 60 million people are infected with HIV
- 20 million have died from AIDS
- AIDS is the fourth leading cause of death
- 95% of all AIDS cases are in the developing world
- 14,000 infections occur daily
- In Sub-Saharan Africa, there are 29.5 million people living with AIDS (PLWA)
- By 2010, it is estimated that there will be 45 million PLWA

In Lesotho

24% of those age 15-49 are infected with HIV

- Females (15-49): 26%
- Males (15-49): 19%

As age increases, infection rate increases

- Females (30-39): 43%
- Males (30-34): 41%

HIV prevalence is higher among women less than 30 years old while ages 40-49 the pattern reverses and prevalence among men increases.

PSYCHOSOCIAL RISKS AND VULNERABILITY FOR HIV/AIDS

Psychological factors and the social context in which HIV / AIDS occurs recognize that mental health is closely linked to culture, tradition and relationship.

Poverty

- Economic position and sexual activity
- Effect of poverty on women and sexual behaviour
- Trading sex
- Less choice for condom use
- Multiple partners for economic protection
- Poverty increases risk of HIV infection, mental disorder and substance abuse

Humanitarian Crisis

- Humanitarian crisis exacerbates HIV / AIDS and vice versa
- HIV prevalence correlates with falling calorie and protein consumption
- Social economics powerlessness
- Men with multiple sexual partners
- Lack of sexual knowledge
- Sexually submissive to men
- Parental death results in orphans who had no skills passed to them in farming and other traditional skills
- Widespread unemployment, social displacement and desperation

Gender Inequality: Infection is higher in women

- Biological Factors
  - Female genital tract more permeable to fluids
  - Higher concentration of virus in semen
  - Women have STI (no access to treatment, stigma and embarrassment)
- Social Perspective
  - Target for sexual violence
  - Traditional myth: sex with a virgin can cure HIV / AIDS
  - Child marriages.
- Economic Perspective
  - Discrimination in housing, education, employment, economic resources & opportunities
  - Women caregivers
  - Women losing assets if husband dies (e.g. land, house)

Stigma and Discrimination

- HIV/AIDS a result of witchcraft
- Discrimination - compulsory testing, notification with women, job opportunities
- Religion - punishment of sins
- Sometimes violent murder
- As a result of fear of discrimination and shame, PLWHA may sacrifice treatment, mothers may breastfeed a baby to hide the status, sex workers may remain in the trade to maintain income

Other Risks

- Existing mental illness - impairs judgment
- Substance abuse - reduces inhibition and impairs judgment
- Level of education and condom use
- Childhood sexual abuse leads to early sexual activity, promiscuous behavior and prostitution

Orphans and Vulnerable Children

- 71% sexually abused children tested positive
- 40% raped children tested positive if with no post exposure prophylaxis; in R.S.A.
- Mental, social and physical development compromised

Neuropsychiatic Disorders Associated With HIV/AIDS

- Fear, anger, guilt, denial and despair
- 38%-73% of clients will have at least one psychological disorder in lifetime
- 20% have psychological symptoms as the earliest manifestation of AIDS
- Neurological changes and side effects of the treatment
- Psychosocial stressor

HIV/AIDS

- Chronic illness
- Lifetime discomfort
- Physical deterioration
- Physical and financial dependence
- Eventual death
- Mental disorders occur in 30-35% among those with HIV/AIDS while mental disorders occur in 15-30% of the general population

Other Pressures

- Family members die
- Stigma, discrimination
- Sexual rejection
- Absence of psychosocial support

BIOLOGICAL EFFECTS

Direct Effect of HIV on CNS System

- Sometimes misconstrued as psychological symptoms
- Opportunistic infections
- Symptoms appear due to structural/functional brain lesion
- ¾ of all HIV/AIDS patients reveal neurological changes
- 30% exhibit multiple lesions in CNS

AIDS Related Opportunistic Infections

- Toxoplama encephalitis
- Cryptococcal meningitis - third most common complication
- CNS lymphoma
- Cytomegalis virus encephalitis
- Progressive multifocal leucoencephalopathy
- Tuberculous meningitis

NEUROPSYCHIATRIC DISORDERS

- 50% of patients have AIDS Dementia Complex
- Impairment in cognitive functions - observation, concentration impaired, memory impairment in information processing, apathy, social withdrawal, irritability
- Within two months of infection, cognitive functions are impaired
- Within three months of infection, cognitive symptoms appear
- Mood disorders 60% major depressive disorders
- HIV/AIDS Mania: 8%
- Psychotic Disorders: 2-15%
- Psychotic PLWA have higher mortality rate than general population

Disorder of Personality
- Not induced by viral infection or neurological changes
- Two personality dimensions:
  - Stability-Instability
  - Introversion-Extraversion
- Unstable people - react very strongly to every situation
- Extrovert - tends to seek reward rather than avoid consequences
- Introvert - more concerned on the outcome
- Instability and extroversion exhibit high level of risky behaviour and worst adherence to treatment; they have more problems in coping than introverts

Disorder of Motivated Behaviour
- 20-73% have substance abuse disorder
- 5% spread due to needle sharing
- Impaired judgment and impulsive behaviour
- Drug behaviour as a coping mechanism to positive testing

Higher Rate of Sexual Inhibition, Impaired Judgment and Impulsivity
- Alcohol abuse - multiple sexual partners, sex with strangers, possibility of rape, failure to use condom, sex with IV drug users
- Major depression precipitate drug/alcohol abuse and decreases personal safety

Mental Disorders in Children
- 50% of the current population in sub Saharan countries are children under 17 years of age - 12% are orphans
- Parents' death - psychological trauma
- Children born to HIV/AIDS patients show symptoms within 4-8 months of age
- Defective motor development and delayed cognitive development
- Loss of short term memory
- Steady loss of early development
- Deterioration in intellectual ability
- Attention deficit disorder and spatial ability disorder
- Deficit in social performance
- Social problems - poverty, housing and lack of social support

Non Adherence to Drug Regimens
- Adherence related to ability to cope and psychosocial support
- Level of depression correlates well with adaptive coping ability
- Strong relationship between mental health disorders and non-compliance with treatment
- Addressing mental health problems is critical in preventing drug resistance

Adequate mental health care / psychosocial support
- Lack of basic needs - nutrition and security
- Knowledge Gap-D/D often difficult - culturally relevant measuring of depression
- Side effects of ARV on cognition and behaviour

MENTAL HEALTH CARE

Mental and behavioral disorders make up 12% of GBD while 28.5% of disability. Common mental disorders include alcohol abuse, bipolar disorders, schizophrenia, OC disorders and major depression. There is a close relationship between psychological disorders and HIV/AIDS and a high cost of non-integration of mental health components in the HIV/AIDS pandemic. Dual purposes can be served if mental health problems are looked after.

Funding for mental health is limited, making up 2.9% of health budgets in general and 5-6% of Lesotho's health budget. There is a lack of specialised staff (including psychiatrists, psychiatric nurses, social workers, and psychologists), which requires training of non-mental health workers. In recognition of the stress that caregivers face, the following measures should be put in place:
- Forum to Discuss Experiences and Stress
- Support Network for Care Givers
- Rest Periods

PHARMACOLOGICAL TREATMENT

For the effectiveness of treatment, drug-drug interactions must be carefully studied and understood to achieve success keeping clients alive without deleterious side effects

- There is no information available for the interaction of alcohol dependence with disulfiram
- Naltroxine Opiod is antagonistic in alcohol dependence.
- Alternative/Complementary Medicine: St. John Wort's for depression is not indicated with ARVs
- Ginco Biloba for memory improvent and Kaya Kava are not advisable

THE WAY FORWARD

Ignoring mental health issues leads to pandemic growth. The relationship between mental health and HIV/AIDS must be addressed.

Primary Prevention
- Stigma and discrimination should be worked on
- PLWHA should have a visible role within Government, NGO and communities.
- Target personal attitude
- Project rights of the PLWHA
- Employment, health care, and community activities

Increase IEC Activities
- Voluntary counselling and testing
- School programme and community activities
- Media campaign
- School sex education

Prevent Mother to Child Transmission
- Nevirapine
- Antenatal and well baby clinics

Secondary Prevention
- Recognise mental disorder risk factors in PLWA
- Effective coping strategies
- Mental health care in primary health care
- Screening and treating mental disorders at primary care
- Reduce transmission among youth
- Assess cognitive development in infected children
- Access to psychotropic medication
- Treatment of opportunistic infections
- HAART (USA death rate decreased by 47% and dementia incidents decreased from 20% to 2%)

Tertiary Prevention
- Improving communication between parents and children on sex, parental illness and death
- Preparing children for life after death of parents
- Child education, economic status
- Future guardian should be named - job training, economic opportunities

Teachers training to offer support
- Encourage interaction between orphans and others
- Help children to express emotions
- Organize projects to raise money with healthy school children
- Memory book project - book that includes pictures of the family, family history, thoughts, feeling and messages for future
- Traditional funeral ceremonies for emotional healing
- On-going interpersonal group therapy

CONCLUSION

Partnership between Government, NGOs, international organizations, faith-based organizations and civil society are important. Mental health must be included in the intervention agenda to meet the needs of PLWHA as well as to reduce HIV/AIDS and any emerging resistant strains of the virus.

REFERENCES

1. Health, Nutrition and Population (HNP) Discussion Paper, January, 2005, the World Bank

2. Practice Guideline for the Treatment of Patients with HIV/AIDS, Arlington, VA. USA.

3. Lesotho Demographic and Health Survey, 2004.

The World Medical Council Policy

WORLD MEDICAL ASSOCIATION INTERNATIONAL CODE OF MEDICAL ETHICS

Adopted by the 3rd General Assembly of the World Medical Association, London England, October 1949 amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983 and WMA General Assembly, Pilanesberg, South Africa, October 2006.

DUTIES OF PHYSICIANS

A Physician shall always exercise his/her indepenent professional judgment and maintain the highest standards of professional conduct.

A Physician shall respect a competent patient's right to accept or refuse treatment.

A Physician shall not allow his/her judgment to be influenced by personal profit or unfair discrimination.

A Physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.

A Physician shall deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.

A Physician shall not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.

A Physician shall respect the rights and preferences of patients, colleagues, and other health professionals.

A Physician shall recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels

A Physician shall certify only that which he/she has personally verified.

A Physician shall strive to use health care resources in the best way to benefit patients and their community.

A Physician shall seek appropriate care and attention if he/she suffers from mental or physical illness

A Physician shall respect the Local and national codes of ethics

DUTIES OF PHYSICIANS TO PATIENTS

A Physician shall always bear in mind the obligation to respect human life.

A Physician shall act in the patient's best interest when providing medical care.

A Physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she would consult with or refer to another physician who has the necessary ability.

A Physician shall respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality

A Physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.

A Physician shall in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.

A Physician shall not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

DUTIES OF PHYSICIANS TO COLLEAGUES

A Physician shall behave towards colleagues as he/she would have them behave towards him/her.

A Physician shall NOT undermine the patient-physician relationship of colleagues in order to attract patients.

A Physician shall when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information.

Declaration of Geneva

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden.September 1994 and editorially revised at the 170th Council Session Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006.

At the time of being admitted as a member of the medical profession:

I solemnly pledge to consecrate my life to the service of humanity; I will give to my teachers the respect and gratitude that is their due; I will practice my profession with conscience and dignity;

The health of my patient will be my first consideration; I will respect the secrets that are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honor and the noble traditions of the medical profession; My colleagues will be my sisters and brothers;

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat;

I make these promises solemnly, freely and upon my honor

Hippocratic Oath

Excerpted from the World Medical Association International

I swear by Apollo the physician and Asclepius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him and to relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of this Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to law of medicine, but to none others.

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous, I will give no deadly medicine to anyone if asked, nor suggest any such council; and in like manner I will not give to a woman a pessary to produce abortion. With purity and holiness I will pass my life and practice my Art.

I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and further, from the seduction of females or males, of freemen and slaves.

Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which out not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot.

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