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From the President's Pen

Colleagues,

I am once again privileged through this mouth piece of our Association to bring to the fore, and as foods of thought for our brains and consciences, issues that I consider fundamental and paramount in buttressing our worth as professionals, that our nation can count on for its development and sustenance. I greet you first of all in the name of God Almighty by whose power, grace and mercy we have this far stood the test of time as we discharge our duties as custodians of health in our dear land. At this point I mention with regret the loss of one of our dedicated and very experienced colleague, Dr Ntutulu Mapetla to the icy cold hands of death. May her soul rest in peace.

In Volume 5 Number 1 (2007) issue of this journal, as I put pen and paper together, I tried to find words that touch on the importance of this fraternity in guarding against fragmentation of its societal spirit in words and deeds as it champions the course of progress in the name of quality health delivery in this land. I challenged you as a people on whom the responsibility of the nation's health squarely lies, to retrospectively assess yourselves and identify what your "individual contributions have been in the life of the fraternity, what it should be and is going to be in the years to come, to ensure that our goals as an association are realised." It is an ongoing battle for us, hence the need for me to reiterate this here once again. The health of our people continues to be a great issue of concern to Government and all well meaning citizens of this country. Our cemeteries continue to expand at a rate that has never been before and if we want to accept realities we would just agree, that if efforts are not doubled in applying the relevant breaks at this point in time to arrest the onslaught on our population by various diseases, particularly the human immunodeficiency virus, our nation faces the real danger of sliding into a health anarchy. Question: What do we do? How hard do we have to pull to win this tug of war game between us as a people and the forces of evil and divisiveness? Forces that indeed tend to divide and rule us in a way as to divert our attentions from the SOS cries of people around us.

Colleagues, as gloomy and bleek as the future may appear to be, let me say without any mincing of words that we still have hope to put things right at the health front. All we need to do is to rededicate and recommit ourselves to the vows we took to serve mankind and also pray for a strengthening of our numerical capacity to dutifully take on the bull. Indeed I have a vision of a day that the African medical fraternity will become one consolidated and united continental body in which ideas and experiences are shared regarding effective patient management for collective emancipation of the continent from disease and poverty. I have a vision of a day when patient management in our country and our continent at large will be seen as team work in which patient care will be a collective responsibility of highly qualified doctors, nurses, pharmacists, physiotherapists, paramedics and administrative support staff, whose training is tailored to the specific health needs of individual countries and who will work together with the one sole objective of providing patients with quality medical care. At the national front and talking about the need and increase in numbers of medical and medical support staff as a dream that needs to be realized in successfully combating disease and poverty, I am personally gratified to take note of efforts Government

is making, to train more of these staff locally. A new crop of locally trained pharmacists who have been given clinical exposure at our teaching hospital will be turned out this year. Absorbed into the health system, I see these pharmacists actively getting involved in patient management in a way that has never been before, to provide a new dimension to patient care efforts in our hospitals. My dreams and visions, no doubt will be earlier realized than one would have been thinking.

Dreams and visions, colleagues, that is all there is from my pen in this issue. They are necessary in directing our focus in what we do in upholding the ideals and safeguarding the interests of our profession. Let us take part actively in patient care and enjoy it. We are custodians of health and let us allow ourselves to be seen in that light. Let us provide optimum health service to all with passion and devotion because "one who giveth receiveth in abundance" so says the word of God in the Holy Bible and other religious books. Let us work unceasingly to ensure that wellness of people around us becomes their right and not a privilege reserved for only those who can afford. Let us expand our view of what we define as wellness so that we can know what to do to meet the aspirations of recipients of our services. Making people well, we should remember, is about how we interact with people around us, how we contribute to the attainment of their expectations of good health without prejudice and also how we experience and make ourselves part of those things that happen to and around us. Indeed, it is about giving more than we take, about caring for those around us and equally about respecting and taking time to look after children, the destitute and needy elderly persons.

May God bless us all in our humble endeavour to serve our people to the best of our ability.

Thank you

Dr C.K. Hoedoafia
May 10, 2007

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:

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Quacks

Order 13 of 1970 of the Laws of Lesotho Section 24 declares that "any person not registered as a medical practitioner who-

(a) For gain, practices as a medical practitioner (whether or not purporting to be registered) or performs any act specially pertaining to the calling of a medical practitioner or
(b) Pretends or by any means whatsoever holds himself out, to be a medical practitioner (whether or not purporting to be registered), or uses the name of medical practitioner or uses the name of medical practitioner of any title, description or symbol to infer that he possesses a degree, diploma or other qualification as a medical practitioner, doctor of medicine, physician or surgeon or that he is registered as a medical practitioner.....shall be guilty, of an offence punishable by fine or imprisonment."

Sections 25 and 26 refer to dentists and pharmacists in a similar manner.

In the past thirty years, there has been significant growth in the number of 'quack' doctors practicing in Lesotho. This phenomenon primarily affects the urban regions of Lesotho, where Chinese practitioners, as well as many people who have worked as ward attendants and nurses in hospitals, refer to themselves as doctors. Radio slots have unbridled hours of proponents for untested drugs and foods, which take the gullible for a ride toward health disasters. All of these practices are in breach of the law. Intervention is required by law enforcement officers in order to save the people of Lesotho from exploitation and destruction of their health.

ETHICS COMMITTEE

In our previous Editorials, we referred to the establishment of a national Ethics committee that would consist of members of the Health Professions Councils, the Ministry of Health and Social Welfare, the National University and members from the relevant faculties and other stakeholders. This committee would regulate any or all bodies which would have interest in the trials of any drugs or any experiments on Basotho People.

We also drew to the attention of all in authority that the number of philanthropists and benefactors for various HIV/AIDS programmes was also increasing and that policies had to be developed and agreed for the safety and regulation of such bodies vis-à-vis a common national goal.

The development of the proposed Ethics committee, which was stalled for about three years, is urgent, and needs resuscitation and installation for immediate action to protect the nation

Dr. 'Musi Mokete
Editor, Lesotho Medical Association Journal

HIV Prevention is Not as Simple as A, B, C:
Going Beyond "ABC" for Lesotho

T LEKHANYA, BSc, MB ChB

There is growing concern in Sub-Saharan Africa that the "ABC" strategy of combating HIV/AIDS is not working, that it is failing. Whilst I feel that the strategy itself is a good one and that people are misinterpreting and not practicing it appropriately, I also feel that it is indeed deficient, and has played a big role in the sex stigma associated with HIV/AIDS and needs to be supplemented. This is my attempt to create a new strategy, based on my 15 years of experience as an AIDS activist and educator. I have focused on what AIDS educators would call "the Drivers of the Epidemic."

Note: *This guide assumes that HIV/AIDS is a disease like any other. The writer does not believe in the stigma surrounding the HIV/AIDS epidemic.*

A = Abstain from sex and **A**lcohol

The association between alcoholism and HIV/AIDS and STDs has been established (e.g. Alcohol Abuse Conference, South Africa, 2007). Lesotho was declared world's number 2 in per capita consumption of alcohol in 1993 (Ministry of Information & Broadcasting). Surely this must be one of the fuels of Lesotho's devastating epidemic. Alcohol also leads to breakdown of societal structures, like families, and there is a lot of HIV infection in the setup of family strife and separation/divorce (see **S** below).

Note: It is silly to say the least, to abstain form sex, and then marry somebody whose HIV status you don't know (see K&L)! Some of us feel the pre-marital HIV test should be compulsory, and Marriage Certificates should have to be renewed every five years, requiring repetition of the HIV test by both married partners, together.

B = Be faithful to one partner (including a married partner)! (See K and L)

C = Condomise (appropriately and consistently). Check for holes in **C**ondoms and **G**loves.

DEFG = Don't **E**ver **F**orget **G**loves when assisting ANY sick or injured person.

HIJ = Handle **I**nfectious materials **J**udiciously
Handle **I**njections **J**udiciously
Hand Piercing **I**nstruments **J**udiciously

Note: Gloves will not protect you if you are using a sharp object like a hypodermic needle.

KL = Know your status, and **L**ive accordingly.

MNO = Medics, **N**urses, and **O**ther health workers
They are not safe; in fact they are a high-risk group!

Their attitudes and approach to the epidemic in Africa have been detrimental. For a long time, health workers have had negative attitudes towards AIDS patients, and have broken professional confidentiality. This has caused a lot of fear. Up to this day, many health workers will still ignore symptoms and signs of HIV infection in a patient (e.g. for fear of falling out of favour with patient). In the meantime, the patient will

unknowingly be happily spreading the virus around. That the debate on whether pregnant women should be routinely tested for HIV has taken more than ten years, while many innocent babies have been getting HIV/AIDS, says a lot about the African continent.

P = Players & entertainers (including sex workers, formerly "**P**rostitutes"), who are amongst the major "Drivers of the Epidemic."

Q = Qacha, **Q**uthing, Mokhotlong (+/- Thaba-Tseka)

These districts are very susceptible due to deprivation and geographic location (the KZN province of South Africa on one side, and the Lowlands of Lesotho on the other). The absence of radio transmission and other media for protracted periods is not helping the situation.

R = the **R**oad.

There is a high degree of migrant work and nowadays, "migrant study." This has devastating consequences for Lesotho. Most important are people working on the mines of South Africa, and the factories and kitchens of the KZN and Gauteng provinces of RSA. These people bring HIV infections into Lesotho over weekends and vacations, and then quickly go back to RSA. The epidemic has indeed gone underground in Lesotho, for those who have been arguing that compulsory HIV testing may drive the epidemic underground. (See ZA Below.)

S = Separation, divorce, marital strife.

In my General Practice, I find that more than 80% of suspected HIV patients, who also have separation, etc, as a risk factor, come out seropositive. People should be even more careful about the need for K&L in this setting**.**

Single motherhood (and maybe **s**ingle fatherhood). Single mothers are over-represented amongst our HIV patients and mortality statistics. Many single parents will be having children by different partners, whose HIV status they do not know!

T = Taxi, bus, and other major "Drivers of the Epidemic." Employees and owners of **T**ransport businesses need to beware.

Teachers & Lecturers and the power imbalance between them and their students should be noticed.

Students must learn to say "NO," even to their instructors, and to report harassment. Teachers have to be made aware that a huge portion of teenagers are already HIV infected. It is a challenge to Government to improve their pay and benefits, and at the same time toughen laws. This may reduce unprofessional practices, and protect the teaching workforce.

U =Uneducated, **U**ninterested, **U**nemployed, **U**nstable, etc, you are at risk.

Urine, vomit, feces, and other bodily eliminations have caused unnecessary panic at times. They will only transmit HIV if there is blood also.

Vaccines, microbicides and other technological advances await a lot of research

Women, **W**idows and **W**idowers are at high risk and perhaps have more urgency for **K** and **L** than other sectors of the population.

Without gender equality, the human race is doomed. Little boys must be brought up and learn to respect girls and women. Certain aspects of culture in respect to widowers, (e.g. "seeantlo") have to be abolished or modified. On the

other hand, some cultural restrictions around widowhood may be beneficial. There seems to be an association between HIV infection and infertility, and I feel at times this is caused by women going into marriages at an early age, and then becoming infertile. The husband may then go around, testing his manhood (the woman may also retaliate!). The dual presence of The Sexual Offenses Act of 2003, and the Marriage Laws of Lerotholi, which allows marriage for women at age 14 in Lesotho, is indeed problematic.

X = Does snipping off the foreskin, circumcision, (imagine a pair of Scissors) protect men against HIV infection? Is circumcision the reason why **X**hosas in Eastern Cape seem to have a lower rate of infection than Zulus in KZN?

Circumcision reduces the risk of infection, but **it does not protect men or women against HIV and AIDS.** How can circumcising the men of Lesotho, more than half of whom will NEVER get tested for HIV, protect the nation?

Y = Youth.

Many challenges face you. Some have been tackled above. Lesotho youth seem to fancy too much; things that are likely to end in tragedy. The biggest problem is the economically powerful neighbour (see **Q** & **R**) with its media and yet-to-be-stable society. HIV awaits those trying to take a short cut out of their socioeconomic circumstances!

Z = ZA (South Africa).

This economically powerful country surrounds Lesotho. For every Mosotho, there are 3 HIV-infected South Africans, and for every Mosotho living in RSA, there are 50 to 60 such persons, who are potential sexual partners at some stage.

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Decentralising Free, Nurse-Based HIV/AIDS Care and Treatment in Rural Lesotho:

The Experience of MSF and Scott Hospital HSA

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INTRODUCTION

In January 2006, Doctors Without Borders/ Médecins Sans Frontières (MSF), an international medical humanitarian organisation, and the Ministry of Health and Social Welfare (MOHSW) signed an agreement to launch a joint pilot programme with Scott Hospital Health Service Area (HSA) to provide HIV/AIDS care and treatment, including antiretroviral therapy (ART), at the primary health care level. Given the overwhelming need for dedicated HIV services, severe human resource shortages, especially in rural areas, and serious geographic access constraints for patients, the goal from the outset was to rapidly decentralise all HIV care and treatment activities to the health centre level.

Scott Hospital HSA straddles Maseru and Mafeteng districts and is responsible for health care provision for approximately 220,000 inhabitants served by one 102-bed district hospital and 14 rural health centres, many in remote, mountainous areas. There are an estimated 35,000 people living with HIV/AIDS (PLWHAs) in the HSA; of these approximately 5,000 are in urgent clinical need of ART. The Scott/MSF programme is the first in Lesotho to achieve full decentralisation of HIV/AIDS care and treatment throughout an entire HSA.

SUMMARY OF ACHIEVEMENTS

From January-December 2006, staff from MSF and Scott Hospital HSA worked hand-in-hand to train and empower nurses, strengthen drug supply and specimen collection systems, improve laboratory capacity, launch HIV clinical activities, identify and train community members as lay counsellors, enhance treatment literacy and community support activities, enroll patients in HIV care, and initiate ART. During the course of the first year the programme achieved the following results, all of which exceed the targets set for 2006:

- 6,631 people counselled and tested for HIV, 2,655 of whom (40%) were HIV-positive
- 3,294 people enrolled in HIV care
- 885 adults and children initiated on ART and 60 ART patients transferred in from other facilities, giving a total of 945 people receiving ART in the programme
- Uptake of HIV testing among first visit antenatal clinic clients at Scott Hospital increased to over 86% (compared with 48% in 2005)

PROGRAMME SERVICES & OUTCOMES

HIV TESTING AND COUNSELLING

In 2005, prior to the introduction of HIV care and treatment services, approximately 1,000 people were counselled and tested for HIV in Scott Hospital HSA. From January-December 2006, HIV testing and counselling (HTC) increased more than six-fold: 6,631 people were tested in 2006, of which 2,655 (40%) were HIV-positive. The rapid increase in uptake of HTC can be attributed to three main factors:

- Availability of dedicated HIV care and treatment services at the health centre level, which created an incentive for people to test;
- Expanded capacity for HTC through the creation of "lay counsellors" and "task-shifting" the responsibility for HTC from nurses to counsellors, thereby reducing the workload for nurses;
- Implementation of a more ambitious approach to HIV testing in keeping with national policy, including such measures as routine offering of HTC for TB patients and clients in antenatal care (ANC), and diagnostic testing of seriously chronically ill inpatients

HIV CARE AND ART

During 2006 more than 3,000 individuals were enrolled in HIV care. Of these, 66% were non-pregnant women, 26% were men, 5% were children under the age of 14 years, and 3% were pregnant women. From March-December 2006, nearly 900 people were initiated on ART and 60 were transferred into the programme from other ART sites in the country. As of this writing (May 2007), there are more than 1,400 people who have ever been initiated on ART in Scott Hospital HSA. Key strategies and activities that facilitated rapid decentralisation of HIV care and ART include:

- Providing theoretical and in-service training for more than 50 nurses and other health staff on management of HIV-related conditions and ART at the primary care level
- Developing and distributing a guideline for nurses on the management of HIV-related conditions and antiretroviral therapy[1] and basic protocols/flowcharts to simplify standard operating procedures
- Establishing MSF mobile medical teams to provide direct clinical care, on-site mentorship, and in-service training and supervision
- Upgrading radio communications systems at all clinics to facilitate communication
- Providing basic clinic equipment (file folders, scales for weighing patients, filing cabinets, shelving for drugs, etc.)
- Identifying, training, compensating, and supervising clinic-based adherence counsellors from among the existing lay counsellors and task-shifting ART counselling activities from nurses to this new category of health care worker

Clinical outcomes: six-month ART cohort analysis

In March 2007, a six-month cohort analysis of patients initiated on ART up to June 2006 was carried out (n=246). In this cohort, median age was 39 years; 75% were women. Median baseline CD4 count was 74 cells/μl, and the median baseline weight was 53.5 kg.

After six months on ART, 210 patients (85.4%) were remaining in care.[i] Twenty-one patients had died (8.5%) and 15 patients (6.1%) were lost to follow-up (LTF). The median (IQR) CD4 cell increase was 258 (187-307) and the median (IQR) weight gain was 5.4 kg (5.1-5.5).

These results are comparable with data from other ART programmes in resource-limited settings which is encouraging considering the serious challenges of delivering ART in such a geographically dispersed, rural setting with severe human resource shortages.

A comparison of outcomes for the hospital versus clinics reveals some interesting points. The clinics account for approximately two-thirds of patients on ART. This underscores the importance of having numerous points of care to increase coverage of ART for those who need it. Although men are slightly more represented at the hospital and the median age is slightly lower, there is no significant difference between the clinics and the hospital in baseline characteristics, with the notable exception of CD4 counts. As is expected, the median CD4 count at ART initiation is lower in the hospital group than in the clinic group, as sicker people tend to go to the hospital.

At six months, clinical outcomes in terms of CD4 and weight increases are comparable between the two groups. However, the proportion of people lost to follow up is three times higher at the hospital.

This needs to be assessed further and may indicate that distance and travel, as well as frequent migration to South Africa especially for male patients, are important issues that need to be addressed. Mortality is also more than three times higher in the hospital compared to the clinics. A higher mortality is to be expected in view of the lower baseline CD4 counts at ART initiation. This mortality figure is similar to that found in St Elisabeth Hospital in Lusikisiki, a rural district in the Eastern Cape of South Africa (13.5 % mortality at 12 months).[2]

Paediatric ART: Six-Month Outcomes

A total of 17 children under the age of 14 years were initiated on ART up to the end of June 2006, representing 6.5% of the total for this cohort. The median age was nine years (Range: nine months to 13 years). Fifty-nine per cent (59%) were girls. The median baseline CD4 percentage was 11%.[ii] The median baseline weight was 17.6 kg. After six months on ART, 16 of the children (94.1%) were remaining in care. One child had died (5.9%), but none were lost to follow-up. The median weight gain was 2.4 kg.

While clinical outcomes are good for children, the proportion of children on ART in the programme is unacceptably low given that approximately 15% of all those in need of ART are typically children. A priority for the coming year will be to ensure increased testing of children and rapid enrollment in HIV care and initiation of ART for those in need.

[i] Four patients out of the 246 initiated on ART through June 2006 (1.6%) were transferred out to other sites.

[ii] Note that this is more relevant for children >7 years.

TB / HIV

As is the case in all high-HIV burden settings, TB is the leading cause of death among PLWHAs in Lesotho. Numerous challenges related to TB were identified in 2006. The first is simply diagnosing TB in HIV-positive individuals; it is also critically important to integrate TB and HIV services given the co-infection rate. In September 2006, MSF conducted a cohort analysis, which showed that of the 221 TB patients actively on TB treatment during that month, 203 (92%) were co-infected with HIV.

Dying of Undiagnosed TB

The traditional test to diagnose pulmonary TB is not very helpful in high HIV prevalence settings: microscopy only diagnoses about 15% of patients suspected of having pulmonary TB in Scott Hospital HSA. The other 85% of patients have 'smear-negative' or extra-pulmonary TB (EPTB), and a diagnosis of TB is usually very delayed, or never made at all, which leads in most cases to TB-related deaths.[i]

A chest x-ray is helpful in diagnosing smear-negative and EPTB in some cases, but this is only available at the hospital and there are significant transport issues that can prevent patients with suspected TB who live in rural areas from getting an x-ray.

Most importantly, since nurses are not presently trained or empowered to diagnose smear-negative TB, a person with TB symptoms and negative microscopy must always see a doctor before being started on TB treatment. This must change. Toward that end, the National TB Programme is supporting validation of a nurse-based smear-negative algorithm by MSF/Scott in 2007.

First Steps Toward Integration of TB/HIV Services

In 2006, MSF and Scott Hospital HSA staff took initial steps to strengthen integrated TB/HIV services and improve diagnosis and management of multi-drug-resistant (MDR) TB. Key strategies to integrate TB/HIV services include offering routine HIV testing for all TB suspects; ensuring a "one-stop service" for TB/HIV co-infected patients, including: systematic TB screening for all HIV-positive patients; same-day appointments for TB/HIV co-infected patients; integration of TB cards and HIV folders; systematic CD4 counts for all co-infected patients; co-trimoxazole prophylaxis and Vitamin B6 for all TB patients (including those co-infected with HIV); and initiation of ART for all eligible co-infected patients.

In order to begin improving diagnosis and eventually management of MDR TB, an interim system for accessing reliable culture and DST in South Africa was established with the National Health Laboratory Service in Bloemfontein. This will be subsidised by MSF until such time as a reliable system exists at the national level.

PMTCT AND EARLY DIAGNOSIS OF HIV IN INFANTS

One area of focus in 2006 was strengthening the existing programme for the prevention of mother-to-child transmission (PMTCT) and improving early diagnosis and treatment of HIV inchildren. These proved to be enormous challenges. The first step was improving and updating the PMTCT protocol to reflect international standards and supplying all necessary commodoties to health centres to allow for decentralisation of PMTCT.[ii]

[i] Because so many cases of TB go undiagnosed in PLWHA, the actual incidence of TB is much higher than the official reported incidence.

[ii] Free acidified formula has been supplied by MSF for clients enrolled in PMTCT who opt to exclusively formula feed.

In order to improve uptake of testing and PMTCT, dedicated lay counsellors were assigned at the Scott Hospital ANC clinic and routinely offered HTC to all ANC clients through group pre-test counselling. PMTCT, labour ward, and infant registers were also introduced in late 2006 in an attempt to improve monitoring and evaluation. However record-keeping is still very poor, making analysis of data extremely difficult.

HIV Testing and PMTCT for Pregnant Women

According to the Scott Hospital ANC register, there were 562 new ANC clients in 2006.[i] Of these, 487 (86%) accepted an HIV test. This is a major increase compared with 2005, when only 48% of ANC clients accepted to be tested. Of the 487 pregnant women who tested, 127 (26%) were HIV-positive. Similar data from health centres was not available.

As of the end of September 2006, the only period for which a folder review was done and reliable data are available, there were 87 pregnant women enrolled in HIV care throughout the HSA, 15 of whom were fast-tracked on to ART (11 at health centres and four at Scott Hospital). Seventy-two (72) patients had CD4 counts >200 and were enrolled in PMTCT.

These data show that there are still enormous challenges to providing a more effective PMTCT service. Chief among these is the fact that few women deliver at a health facility in Lesotho.

Finally, it has proven to be very challenging for nurses to implement PMTCT at the clinic level, and poor record-keeping makes monitoring and evaluation a major challenge. A radically simplified protocol and strategy for PMTCT at the community/village level will need to be explored in 2007.

Early Diagnosis of HIV in Infants

In April 2006, Scott Hospital became one of five pilot sites in the country for HIV DNA polymerase chain reaction (PCR) testing to improve early diagnosis of HIV in children under 18 months. Formal training was provided for hospital staff[ii] and ongoing in-service training was provided by MSF mobile medical teams at clinics. In July 2006, kits for collecting dried blood spot (DBS) samples were provided to each health centre to facilitate decentralisation of PCR testing.

Between April and December 2006, 117 HIV-exposed babies were tested for HIV using PCR throughout the HSA, 29 (25%) of whom were HIV-positive. This includes all HIV-exposed infants PCR tested (not only PMTCT babies) and so the positivity rate is therefore not a reflection of the efficacy of PMTCT in Scott Hospital HSA. HIV-positive children were immediately enrolled in the programme and ART was initiated for those in need.

Toward the end of 2006, turn-around times for receiving PCR results started to increase from four weeks to as much as eight weeks. It is hoped that the Central Lab can contribute to ensuring turn-around times are reduced in 2007.

[i] Not including those seen at the Adolescent Health Corner.

[ii] Training was provided by the Central Laboratory from Queen Elizabeth II National Referral Hospital, Clinton HIV/AIDS Initiative (CHAI), and Baylor College of Medicine, in coordination with MSF.

CONCLUSIONS AND RECOMMENDATIONS

Despite the numerous challenges faced, the first year of the Scott/MSF HIV/AIDS care and treatment programme has been a success, surpassing all objectives in terms of numbers of patients enrolled in HIV care and treatment. The key characteristics of the programme that enabled rapid introduction of dedicated HIV services are listed below. These approaches could be beneficial for ART programmes in other districts and/or HSAs:

- Decentralising ART provision to the primary care level (as opposed to referring patients down from hospital to clinic) provides many more access points to treatment and reduces bottlenecks to enrollment;

- Empowering nurses through intensive theoretical and practical training to be able to stage patients, diagnose and treat OIs, initiate ART and refer complicated cases is essential for maximising efficiency at the primary care level;

- Establishing mobile medical teams for weekly clinic visits to provide direct clinical care, on-site mentorship, in-service training and supervision, and referral support for complicated cases is crucial to ensure adequate support, supervision, and quality;

- Task-shifting certain key responsibilities – notably HTC, ART preparation, adherence support, and other clinic support activities – to non-professional lay counsellors (primarily PLWHAs) who are trained, supervised, and compensated is indispensable to overcome nurse shortages;

- Integrating HIV clinical care into existing primary health care activities, as well as PMTCT and TB programmes, is beneficial for staff and patients and should be promoted over more vertical approaches;

- Strengthening lab capacity at the district hospital level and introducing a specimen collection system to ensure reliable collection and reporting of results and minimise the need for patients to travel to Scott Hospital is critical;

- Reinforcing pharmacy capacity at hospital and strengthening drug supply and stock management capacity at clinics is of critical importance;

- Empowering PLWHAs with knowledge and information about HIV/AIDS and treatment is key to promote adherence and openness about HIV.

Three major overarching challenges lie ahead for ensuring sustained scale-up of care and treatment for PLWHAs in Scott HSA. These include overcoming serious human resource shortages, ensuring access to free 'essential' HIV care in a user fee environment and addressing the threat of drug-resistant TB.

In addition, several important programmatic challenges and priorities remain. These include:

- Devising innovative clinic strategies to cope with the growing numbers of people in need of ART, including further task-shifting and out-of-clinic solutions;

- Establishing a defaulter/contract tracing system for ART and TB patients;

- Improving national ART guidelines to address toxicities in standard first-line regimens;

- Increasing testing, enrollment, and initiation of ART for children;

- Simplifying the PMTCT protocol, increasing uptake of PMTCT, and improving monitoring and evaluation for PMTCT;

- Improving diagnosis and management of MDR TB, including exploring decentralisation of MDR TB treatment.

The Scott/MSF programme has made remarkable progress in the last year. Care providers, community members, and PLWHA have together ensured that thousands of people are getting the care and treatment they need. The programme has the potential to continue expanding HIV/AIDS care and treatment to many more people, but it will only succeed if the challenges outlined above, particularly the human resource situation, are addressed. Innovative strategies and novel approaches will be essential to further scale-up care and treatment and increase access to the dedicated HIV services that have become a lifeline for thousands of Basotho.

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Raising Cancer Awareness in Lesotho

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Throughout developing countries, there is a growing realization that the cancer burden is increasing. Concerned international agencies are sounding early calls to governments world wide to put cancer control firmly on their public health agendas. An example of this is the "Cape Town Declaration on Cancer Control in Africa," made in December 2006.

In Lesotho, similar to other countries, the situation regarding cancer control has not been a priority. However, when we consider that the high mortality from the most common cancer in Lesotho, cancer of the uterine cervix, is largely preventable through targeted screening, early diagnosis and treatment, we can see that it is high time cancer control become one of our priorities.

Broadly speaking, the cancers common in Sub-Saharan Africa can be linked to:

- Infectious agents (e.g. Hepatitis B virus, HPV, HIV, H. pylori)
- Lifestyle and diet (e.g. alcohol related cancers, smoking related cancers) and
- Environmental factors.

All of these factors, with the right focused strategies, lend themselves to some form of control, if not outright prevention.

Various fora have established that effective cancer control requires "National Cancer Control Plans covering cancer prevention, early detection, treatment, palliative care and support for cancer patients, their families and caregivers.[1]" In a country with limited financial and human resources like Lesotho, there is a need to integrate the various facets of a national cancer plan into what already exists, with some additional skill augmentation.

Despite the lack of accurate reporting, referrals from QE II Hospital indicate the following to be common cancers in Lesotho:

Childhood*:*
Leukemia
Kaposi's Sarcoma
Nephroblastoma
Retinoblastoma

Adult Female*:*
Carcinoma of the cervix
Carcinoma of the breast
HIV associated cancers
Less Common:
Lymphomas
Colon cancer
Rectal cancer

Adult Male:
Cancer of the prostate
Cancer of the oesophagus
Oral cavity and larynx cancers
Less Common:
Cancer of the rectum

Lesotho faces many challenges in cancer management, for example: late presentation of symptoms, lack of skilled personnel, limited facilities for staging and treatment, poor record keeping, the lack of a cancer registry, no palliative facilities and virtually no community advocacy groups for cancer. These challenges, however, are surmountable. We can build on some of the structures that have grown up in the fight against HIV, and mobilize to raise awareness for cancer patients.

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Cultural Male Circumcision and its Acceptability

T.K.M. Letsie, MD

INTRODUCTION

The suggestion that the incidence of male circumcision in Lesotho is 0% seems to be dangerous guess-work, obviously different from the true facts in the field. Recording of health statistics in Lesotho has always been problematic. Epidemiology and good health planning rely heavily on the collection of accurate health statistics.

Based on informal data obtained from the 24 principalities and wards of Lesotho, our estimate for the number of male circumcisions performed in the year 2004 was 10,000. It is true that demand for cultural male circumcision in the initiation schools has considerably decreased in the last fifty years. Urbanization and change of harsh training of the males in Lesotho are important factors that must be taken into consideration in appreciating male circumcision in this millennium. The HIV/AIDS pandemic is a serious problem for Sub Saharan Africa.

Male teenagers of my day hated smelly substances under their foreskins (smegma), and in my village we were ashamed of urinating in the presence of our initiated peers. We secretly observed that our initiated male peers had their prepuces removed and were hiding their penises when urinating. Their behavior was different.

Older boys helped to cut the frenulum (moqaqa) by piercing under it with "sefeamaeba" (thorn of shrub Celastrus buxifolius) then threading "bolitse" (hair of the tail of the cow) and tying a knot. The piercing of the frenulum was painful. It was dressed with pounded leaves of seletjane (Hermannia depressa) for some days until cut on its own. It was a secret not revealed to mothers and sisters on pain of punishment by the peers. That facilitated retraction of the prepuce and cleaning of the glans penis.

HISTORICAL BACKGROUND

The penis is an organ of the covenant. Old women blessed it whenever they saw a small undressed boy, by touching together three fingers (thumb, forefinger and middle finger) and snuffing them and saying "Thia" as if it was tobacco. Refer to Genesis 1:28 to appreciate the meaning of the blessing.

Male circumcision is referred to in the Bible as the covenant between Abraham and God (Genesis 17: 1-14 and Joshua 5: 2-8). It is also mentioned in the Holy Qu`ran. Historians and theologians should relate African Male Circumcision (M.C.) to the Bible and Qu`ran. It is an important part of Basotho culture in high demand to this day.

We cannot rule out the influence of Imhotep (Egyptian genius and father of African medicine) on the Bafokeng medicine, while they were still in Egypt before their migration southwards. African traditional medicine seems to a have relationship with Imhotep`s cult during Greco-Roman times, "when his temples in Jazirat Filah in the Nile were often crowded with sufferers who prayed and slept there with the conviction that his spirit would reveal remedies to them in

their dreams." The present spoken Southern Sesotho is the Sefokeng. The nucleus of Moshoeshoe`s chieftainship at Qhobosheaneng in Butha-Buthe was donated by his Mofokeng maternal uncle Ratšiu.

Ramakhula the owner of the Thaba Bosiu initiation school where Letsie and Molapo and 600 initiates underwent their initiation in 1828, was a Mofokeng traditional doctor. Five years later (1833) E.Casalis and his group arrived in Lesotho and lived in Thaba Bosiu among Basotho.

With all respect to the Reverend Mr. E. Casalis and his group, we believe that being the first Europeans to live among Basotho made a serious mistake in suggesting that initiation rites were circumcision, while it might have been just a small operation related to the rite. (Chapter XIII on notions upon the origin of things, religious ideas). He states: "Of all the institutions that tradition has handed down to them, circumcision is the one to which the South African tribes appear to cling with the greatest tenacity. This rite must at its origin have made a deep impression on the human mind, as a symbol of moral transformation." Circumcision as a surgical operation is considered to be part of initiation. It is a "koma" that I have no right to talk about in this forum.

It is also fair to refer to the memorandum of E.S. Rolland of 30th March, 1868 vol. 1V, part 1 1868. S5/9 pp125-151 and the letter from Rev. P Germond to Sir H. Lock KC. B, of 12 January, 1891. It explains why some initiation activities went underground and became a national secret (koma) in Lesotho. Moshoeshoe personally instructed his grandsons Joel Molapo and Lerotholi Letsie to be custodians of initiation rites. His Majesty the King, in his capacity as "morena e moholo," is the custodian of initiation rites, where it is his perogative to introduce innovations that include hygiene, safety and life skills. The tragedy is that all principal chiefs except Ha Ramabanta and Bela Bela have not been traditionally initiated. The National chairman of Initiation Schools Advisory Committee suggests Qeme as a Southern Africa Gilgal for male principal chiefs of Lesotho and South Africa.

DECISION OF THE CABINET OF MINSTERS

At the meeting of Cabinet of Ministers on 21 October, 2003, the Scaling Up Document was adopted as a Lesotho Working document. The following decisions were passed:

(1) Cabinet has adopted the document of *Strategies for Scaling up the Fight Against HIV/AIDS* as an official working/reference document on HIV/AIDS.

(2) Formation of a new broad-based National Aids Commission (NAC) with the Lesotho Aids Programme Coordinating Authority (LAPCA) as its Secretariat made up of:

- A chairman, an eminent and respected individual who will be nominated by PM, and five other commissioners representing:

    a) People Living with HIV/AIDS
    b) Faith-Based Organization
    c) Women
    d) Private Sector
    e) Youth.

(3) The Government will, with immediate effect, draft enabling legislation for the establishment of the National AIDS Commission.

(4) All government sectors and programmes will core-stream the fight against the pandemic at all levels and each sector will develop the capacity to ensure that this takes place as a matter of urgency.

The document appreciates the fact that **all Principal Chiefs would ensure that all traditional leaders (including traditional healers, owners, "principals," and "teachers" of "Initiation Schools") under their jurisdiction throughout the country will become HIV/AIDS competent before the end of 2003.** The total number of chiefs and headmen in Lesotho is 1,954, including 22 principal chiefs and 2 ward chiefs. In 2001, there were 12,045 registered traditional health practitioners. In 2004, the estimated number of men who had undergone Traditional Initiation rites in Lesotho was 10,000.

The Ouagaduougou resolution AF/RC50/R3 on "Promoting the Role of Traditional Medicine in Health Systems" was adopted in 2000 and the Heads of African Governments declared 2001 to 2010 as a decade of Traditional Medicine.

The 55th WHO Regional Committee in Maputo declared 2006 as the "Year for Acceleration of HIV Prevention in Africa." African traditional healers are expected to promote prevention as providers of health care using plant, animal or mineral products and also can discourage unsafe skin-piercing procedures.

Initiation rites played an important role in the liberation struggle of Lesotho against colonialism. Botched circumcisions in Lesotho, Free State and the Eastern Cape have given opponents of traditional rites reason to enact reactionary laws. There is more emphasis on *mistakes* rather than *solutions* to the problems. Loss of lives in the initiation schools is preventable and unjustifiable.

The 1986 Royal command by the Late King Moshoeshoe II:

i) To compile an inventory of commonly used medicinal plants of Lesotho and
ii) To render initiation schools safe and respectable.

Dialogue and interaction with traditional practitioners took place for these many years. Quthing was a focal point. One interacted with the Baphuthi, Basotho and Xhosa traditional practitioners.

CLINICAL TECHNIQUES

As a young man, I was a surgical intern under Mr. Siddique and had a chance to perform many circumcisions, using:

1) Forceps guided method
2) Ishmaels clamp method
3) Circumcision shield method

All these procedures required a theatre operation and professional surgical skills that could not be used in the bush, where over 10,000 operations are done annually with or without allopathic professional knowledge. Botched operations in the bush were special concerns for His Majesty King Moshoeshoe II in his capacity as protector of the initiation rites.

A few years ago, we invited Dr. M. Chabula (a woman doctor and personal physician for president Mbeki's late father) to train Lesotho doctors on the use of Tara Klamp.

Traditional principals of initiation schools were displeased with the role of a woman, hence their "Cultural Immune System." Males in Lesotho and South Africa still believe that "Mafitoane a ka roba lipelesa"(women add to the burden). Men forget the fact that great women like Mofumahali `Manthatisi and `Mantšebo played a better role than men in administration.

The inventor of Tara Klamp, Dr. G. Singh, supervised the training of traditionally initiated paramedics of LDF and two traditional surgeons from the principalities at Ha Matsie and Thaba

Bosiu in November 2005. Dr. G. Singh is a Malaysian with experience in mass adult male circumcision.

With limited resources, we are continuing to educate the paramedics who were trained in Thaba Bosiu on field operations. We have successfully done Tara Klamp operations on over 20 volunteers age 20 to 55. For these operations, we applied traditional *Masia 1 powder* for quick healing of wounds, and used Lidocaine 2% for local anesthesia. Group counseling on HIV / AIDS, condom use and behavioural change, and sterilization of scarification lancet (lehare) with a spirit lamp was recommended.

Estimated cost per operation M240 (Traditional cost over M200)
Target number of principality trainees: 3x24 =72
Total number of required volunteers = 970.

EXPECTED OUTCOMES

(1) Principal Chiefs would be empowered in a nonpartisan manner to spearhead a fight against HIV / AIDS in a permanent and cost effective manner.

(2) Training would have an exponential effect when the trained Thipane-Ramache / Ingcibi would train their counterparts in the principality / ward.

(3)Lesotho would be capable of handling expected demand for MC when the Orange Farm findings are validated by the scientific community.

(4)Principalities should be supplied with initiation kits (Adapted UNICEF TBA kit).

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A Suggested Modification of Alvarado Score as an Admission/ Referral Criterion for Cases with Right Lower Abdomen Pain

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ABSTRACT

To make decision making easy for admission/referral of cases of right iliac fossa pain, a pilot study was conducted at Makoanyane Military Hospital (MMH) to evaluate a modification of Alvarado Score. In our modification, we replaced white blood cell (WBC) count and shift to left, used in original Alvarado Scoring system with two clinical criteria; namely pulse rate and Psoas/Obturator Test.

INTRODUCTION

Incidence of acute appendicitis is relatively low in rural Africa,[1] but it is on the rise[2,3]. Various clinical scoring systems[4, 5, 6] and radiological investigations[7, 8, 9] have been used to make the diagnosis of acute appendicitis infallible, but even today, clinical judgment is the most reliable tool[10, 11].

If the services of a surgeon are available, diagnosis of acute appendicitis will most likely be made on clinical grounds. Yet, in a remote health care centre being run by a nurse, it will be worthwhile to have a standardised protocol for referral/admission of cases with iliac fossa pain. Alvarado Score (Table 1) is one such scoring system that has been found to be simple and useful[4, 12]. However, Alvarado Score uses WBC count and shift to left as two of its assessment criteria. In a setting where a facility for routine haemogram does not exist, as is the case in many rural health care setups, it cannot be applied. We therefore substituted these two with two clinical criteria, namely tachycardia and Psoas/Obturator test. We conducted a pilot study to evaluate this modified system in MMH.

In this paper, we are publishing the results on completion of an eighteen-month study. Though the significance of the results can be highly debated because of the miniscule size of the study so far, some are very interesting and deserve a second look.

MATERIALS AND METHODS

All the patients with right iliac fossa pain reporting to MMH were clinically examined by the surgeon and evaluated with routine haemogram and microscopic and biochemical examination of urine. Irrespective of these scores, the decision to treat the patient on OPD basis or to admit and observe/operate was taken by the surgeon. Only those cases that posed diagnostic dilemma were subjected to ultrasonography (USG) examination at Queen Elizabeth II hospital. Once the surgeon made his decision over a case, the patient was evaluated for his/her modified Alvarado Score (Table 1). The Scoring was repeated after six hours for those who stayed in the ward for observation for more than six hours.

Table 1

ALVARADO SCORE		MMH MODIFICATION	
CRITERIA	SCORE	CRITERIA	SCORE
Migratory Pain	1	Migratory Pain	1
Anorexia	1	Anorexia	1
Nausea/Vomiting	1	Nausea/Vomiting	1
RIF Tenderness	2	RIF Tenderness	2
Rebound Tenderness	1	Rebound Tenderness	1
Fever	1	Fever	1
WBC Count	2	Tachycardia	1
		Positive Psoas/Obturator Test	1
Shift to left (an essential component of Alvarado Score dropped in Kalan Modification[13]	1		
Total	10 (09 in Kalan Modification)		09

The scoring system was evaluated against the clinical acumen of the surgeon and not the final histopathological diagnosis. This was done with a view to the fact that our goal was not to reduce negative appendicectomy rate, as the original Alvarado Score, but to establish an easily reproducible clinical scoring system for admission/referral from periphery.

Here it will be worthwhile to mention that the surgeon was wrong in his assessment on at least four occasions. One patient admitted and discharged after 24 hrs of observation was readmitted within 24 hrs and underwent emergency appendicectomy by the same surgeon. In two cases operated as acute appendicitis, the appendix was found to be normal (a negative appendicectomy rate of 22%) and in one case, there was a pathology unrelated to the appendix.

RESULTS

1. Over the eighteen-month period, forty-two patients reported to MMH with pain in the right lower abdomen as their chief complaint. Twenty-two of which were male and twenty female, with age ranging from eighteen to fifty-three years (no pediatric age patients).

2. Twenty (twelve male and eight female patients) were sent home from OPD with oral medications. The Modified Score in the males in this group ranged from 01/09 to 04/09, while those for the females ranged between 01/09 to 05/09.

3. Out of the twelve patients admitted with a provisional diagnosis of acute appendicitis, one had an appendicular lump and one had progressed to pelvic abscess at the time of admission.

On the other hand, a female with a score of 07/09 was discharged after 72 hrs of observation and a normal USG report. The score in both sexes in this group ranged between 05/09 to 08/09.

4. One male patient admitted with a score of 08/09 underwent exploratory laparotomy due to features of generalized peritonitis and proved to be a case of acute pancreatitis.
Though his appendix was found to be normal per operatively, it was removed.

5. Nine patients (three males and six females) with right iliac fossa pain were admitted by the surgeon for observation and discharged subsequently with diagnosis other than acute appendicitis. The scores in this group ranged between 03/09 to 05/09 in males and 03/09 to 07/09 in females.

6. Migratory pain was a feature in acute appendicitis (pathologically proven) in only four out of nine cases (44%).

DISCUSSION

It is interesting to note from the results of this study that no patient, of either sex, whose score with 04/09 or less required any surgical intervention. On the other hand, all the patients with a score of 05/09 and above required either some form of surgical intervention or repeated clinical examination/advanced diagnostic aid for their management.

However, no conclusion can be drawn from these results because of two clear reasons. Firstly, the study size is too small and does not include pediatric age group of patients. Secondly, the surgeon who was responsible for decision making in different stages of management was also the one allotting the scores, thereby always leaving a possibility of an inherent bias in the study.

Having said that, since the study was aimed at exploring the possibility of a clinical scoring system to aid the health care workers in periphery with decision making in cases of right iliac fossa pain, it appears to have a promise. The following changes in the protocol will probably make it more fruitful:

(i) Scoring should henceforth be done by nurses not otherwise involved in decision making,

(ii) Absence of vaginal discharge/dysurea in females can be included as criteria in the scoring system.

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