



GOVT FUMBLES HIV PREVENTION TENDER

South Africa will be without its flagship Khomanani HIV and TB prevention campaigns for at least 3 months because its Director General of Health missed the boat on putting the 2-year contract back out to private tender.

Industry insiders described Director General Thami Mseleku's proposed solution, that the Government Communications and Information Service (GCIS) undertake a 'temporary caretaker role' during the re-tendering as 'laughable'. They said the GCIS, whose own staff expressed surprise and bemusement upon being told this by the actual service providers, was 'woefully incapable' of managing such a multi-faceted role. 'They can book a few TV ads but the door-to-door campaigning and direct community involvement with a brand name people know is beyond them,' said one.

The campaign's collapse will embarrass government, which declared 2006 'the year of accelerated HIV and AIDS prevention', with special emphasis on intensifying communication campaigns to prevent the spread of the virus. Government has spent more than R300m on the high-profile campaign over the past 5 years.

Mseleku cited the need for an 'independent evaluation' of Khomanani's work as the reason for the lack of continuity, but failed to explain why this was not done well in advance of a known tender expiration date (15 July). Neither did he mention that independent evaluators, which included top academics from John Hopkins University in the USA, had completed a favourable evaluation of Khomanani at the behest of the service provider itself.

Gross incompetence at worst

'It's disingenuous at best and gross incompetence at worst,' one angry industry source said. Not only does

the country's biggest HIV prevention campaign come to a grinding halt with warehoused brochures, posters and pamphlets set to last, at the most until August, but so does Khomanani's 'HOLA 6' TB prevention campaign.

The accelerated TB prevention campaign ran over the first 6 months of this year in response to the Maputo TB Conference declaring TB a burgeoning regional crisis.

Rumours were rife that other vital HIV-related tenders, including voluntary counselling and testing kits and condom acquisition, were also in danger of suffering similar fates through apparent administrative incapacity or incompetence.

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Mseleku said on the radio programme 'Morning Live' on 26 July that his department would use the services of the GCIS until the new contract was awarded and promised that a tender would be made public 'in the next 2 - 3 weeks'.

A list of *Izindaba* questions e-mailed to the health department's communications office 3 days before our deadline 'was referred to' Mseleku's office and when no reply was forthcoming, spokesperson Charity Bhengu promised to 'keep in touch'.

'I am snowed under with work and will not be able to make a follow up to your enquiry. I am sorry, this might take time, please bear with us,' she replied.

This is not the first time lack of tender vigilance has resulted in *ad hoc* measures being put in place (the Khomanani contract expired in March this year and was hurriedly extended for 4 months).

In 2003 Khomanani's seminal 2-year tender was extended by 7 months to enable government officials to complete the paperwork and administration needed to once again open the contract up to competition. Khomanani re-secured the contract from among 30 - 40 contenders.

Flag waving in vain

Sources close to previous and current contracts said it could take 6 months or longer before a new tender was finally awarded. They said the nervous tender holders, bruised by previous experience, began 'agitating in November last year' for the re-tendering process to get kick-started. In spite of their extension, when nothing happened by early this July, 'they realised it was a lost cause', said one.

Khomanani was jointly run by Johnnic Communications (R149.6 million contract for mass media) and Meropa Communications (R35 million for social mobilisation).

Some 1 300 field workers will lose a monthly stipend of about R600 each and the 60 Johannesburg Red Ribbon head office workers will either be retrenched or placed elsewhere.

The independent evaluation commissioned by Khomanani found that field teams had visited some 2 million households at 27 carefully chosen sites countrywide. Voluntary counselling and testing had since doubled in these areas. Half of Khomanani's social mobilisation budget went into this project. The company had also achieved '90% brand recognition', something Mseleku has highlighted.



Prevention, care and support messages had had a 'deep impact', while support for vulnerable children and condom usage were up 'by widely differing numbers'.

No concurrent assessment

Professor Salim Abdool Karim, Director of the Centre for AIDS programme of Research in SA (CAPRISA) and a Vice Chancellor for AIDS at the University of KwaZulu-Natal, expressed shock that so much money was spent without a concurrent impact assessment.

'You don't do this when you're finished. You measure a whole lot of variables along the way and then measure your data and adjust your messages accordingly. A huge programme of this nature needs planning alongside ongoing monitoring and evaluation.' He supported the 'principle' of not renewing contracts without knowing what value was delivered.

Mseleku said no further extension of the contracts had been discussed with the outgoing service providers but they were 'free to submit a proposal should they wish to do so'. He conceded that government had 'not determined' whether it had the capacity to take over the various Khomanani initiatives. An *Izindaba* industry source said that if government did not like what current service providers were doing it should 'do a probe 6 months before a tender ends, but don't let it collapse in a heap and run around lying to the public, telling newspapers you have enough

ware-housed material to last until December', he added.

One of the Khomanani staffers said that 'even our harshest detractors in the Treatment Action Campaign feel we've made a real difference'. He said Khomanani's work had to be reviewed in the context of having consciously complemented the LoveLife (12 - 17-years-olds) and the Soul City campaigns.

Professor Jerry Coovadia, Victor Daitz Professor of HIV/AIDS Research at the University of KwaZulu-Natal, described the saga as 'recurring incompetence and inefficiency in handling critical but straightforward managerial elements for the control of the AIDS epidemic'.

Education interruption 'fatal'

Peter Babcock-Walters, Director of the Mobile Task Team based at the Health Economics and HIV/AIDS Research Division at the University of KwaZulu-Natal, likened the interruption of a communications campaign to the interruption of antiretroviral treatment. 'Essentially you are condemning the patient to an early death'.

He described the collapse of the campaign as 'absolutely inane - you can't interrupt a flow of information when it's supposed to be in support of a national ARV roll-out'.

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Dr David Harrison, executive director of LoveLife, said that besides the gaping hole left by Khomanani (which he first learnt of from *Izindaba* on his return from holiday in Scotland last month), there were 'glaring gaps' in combined existing strategies.

LoveLife has service level agreements with the departments of health, social development and sport and recreation in several provinces. It was saved from crisis at the beginning of the year when government stepped in with bridging finance after the Global Fund for AIDS, TB and Malaria halted funding.

Harrison's concerns centre on vulnerable and often unemployed women, aged 20 - 24 years and living in informal settlements and farms, and domestic workers. 'In accelerating HIV prevention, there has to be an even greater segmentation of the behaviour change efforts to ensure we're covering all the bases. We know we need to sustain our efforts aimed at young people, but given the patterns of infection and sustained high HIV incidence of between 4% and 6% among these women, we have to target them and intensify our efforts with very specific, comprehensive interventions,' he said.

Chris Bateman



NEW TRIAGE SYSTEM HALVES MORTALITIES

A nurse-friendly triage system that halved mortality at the JF Jooste Hospital emergency unit serving the trauma-ridden Cape Flats is in the offing for the entire country – if national and provincial health departments can co-ordinate planning.

Already in use at 75% of Western Cape public hospital emergency units and at proactive individual state hospitals in Limpopo, the Eastern Cape, Gauteng and the North West, the colour-coded protocol is tailored to South Africa's unique needs.

It was described by its champion, Dr Clive Balfour, Chairman of the Emergency Medicine Society of South Africa, as highly effective in preventing unnecessary loss of life and in protecting health workers against medicolegal claims. 'The shocking truth is that by and large there is no uniform triage system. People are used to coming in on a first-come, first-served basis. A nurse asks them to fill in a form and have a seat. Most doctors have their hands too full to witness

what's happening in the reception area – we have to stop this circus,' he told *Izindaba*.

The halving of emergency unit patient deaths at JF Jooste Hospital during a piloting of the system in April 2004 caught the attention of health chiefs in the Western Cape.

They promptly allocated R500 00 for training and wider implementation. The original pilot study was conducted a month earlier at the Stellenbosch Medi-Clinic.

Private health care well advanced

With the exception of the Eastern Cape, all the private hospital group's 30 emergency units are scheduled to implement the new triage by end of the year. Balfour, who is also head of emergency services for Medi-Clinic, said the South African Triage Group, formed at the international trauma congress in Durban this June, had already had enquiries from several overseas countries.

Dr Lee Wallis, Chairman of the SA Triage Group and head of emergency medicine for the Western Cape, said he knew of two hospitals in Poland and one in New Zealand that had begun using the new local triage tool. The profile of emergency patients in most developed countries differed from the South African one, where one-third of all emergency patients suffer trauma.

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The value of the tool locally becomes all the more evident when one considers that the trauma percentage of emergency patients stands at just 8% in the UK and 12% in the USA.

Balfour said the twin ongoing epidemics of trauma and HIV/AIDS dictated the profile of patients seen in local emergency units. In addition, the severity of the injuries seen in South Africa was greater than in many countries, largely because of drunk driving and interpersonal violence.

Hands-on training

Ms Michelle Twomey, a graduate of UCT's School of Public Health, has been employed exclusively by the Western Cape health department to 'train the trainers', trouble-shoot and monitor the new system. She told *Izindaba* that every additional enrolled nursing auxiliary (ENA) appointed in the district health services had gone into intensive triage training.

Clinical nurse practitioners (CNPS) were 'handling the minor cases (code green), so these don't clog up



Cape Metro Rescue workers extract the injured before conducting triage and rushing them to hospital.



the system'. Code red was for life-threatening conditions – to resuscitation area for immediate attention, orange was for serious conditions needing attention from a doctor within 10 minutes, yellow for attention after red and orange patients, green for acute primary care type medical problems (for attention asap), and blue for those already dead.

'ENAs are ideal people to do triage so we've been targeting them. They feel extremely excited and very empowered,' she said. Twomey stressed that training had to be comprehensive, 'otherwise we're setting them up for failure'. She said she was 'slowly getting all hospital staff members on board'.

'There aren't always people who accept structural change in their department. Those who have are taking ownership of it – it's working really well in specific facilities.'

By using a system based on 'vital signs, physiology and discriminators' instead of 'an informal eyeballing triage system that fell on the shoulders of the doctors', health care workers now also had more medicolegal comfort. 'It is also the ideal surveillance tool to audit any emergency unit and you can immediately see the percentages of acuties,' she added.

Nurses equal doctors in triage

Balfour said that with proper training, nurses and emergency pre-hospital workers coded patients as accurately as any doctor. Dr Roy Chuunga, deputy medical superintendent at JF Jooste, said that before the triage system was put in, the average waiting time for a patient was 3 hours.

'Now we can pick the very sick out of the crowd. Red patients are seen

'Two of us waded through about 30 - 40 patients. When we were finished we looked up and saw an elderly man sitting in an armchair. He was dead – he'd gone unnoticed.'

at the very latest within 10 minutes. That's contributed directly to the lower mortality rates'.

Their emergency medical profile was of HIV with complications while the surgical profile was gunshots, stab wounds and other violence-related trauma.

The downside of the triage was that green-coded patients could wait 'for up to 8 hours on a busy casualty day – double the time they used to before'. He said he was battling to address this within existing staff constraints.

Balfour said a defining moment in igniting his passion for effective triage came while working as a junior family physician in a very busy emergency facility. 'Two of us waded through about 30 - 40 patients. When we were finished we looked up and saw an elderly man sitting in an armchair. He was dead – he'd gone unnoticed.'

State-of-the-art EMS care

Dr Wayne Smith, deputy medical director for emergency medical services in the Western Cape, revealed that within a month a new satellite computer system prioritising ambulance and rescue vehicle calls and linking real-time patient data to dispatch and receiving facilities would be piloted in his province.

Clinical data could be punched into a mobile data terminal mounted in

rescue vehicles. The computer would use the new triage system to score and colour-code the patient. An 'electronic note' would then be transmitted to the emergency unit, allowing doctors to be prepared appropriately. 'There should be a continuum of care from the moment a patient is picked up,' Smith said, adding that he believed the computer and triage systems were applicable 'anywhere' in South Africa.

In time for World Cup 2010?

Mr Peter Fuhri, national director of Emergency Medical Services and Disaster Management, estimated it would take 'about 2 years' for a triage system to be implemented nationally. 'I was introduced to it myself for the first time by Lee (Wallis) this morning (18 July),' he revealed. They were discussing FIFA (World Cup 2010) matters.

Fuhri explained that the triage protocol would 'have to be run through' the Medical and Dental Board, the Emergency Care Board and the Nursing Council 'to ensure that it fits in with what they're doing'. Then he'd propose its introduction in each province via the national health council technical committee 'so that it becomes a national project with norms and standards'.

'If we can support it nationally then provincial budgeting becomes less of a problem – it's not a lot of money for training, documentation and implementation when you look at the bigger picture,' he added. As with so much capacity building at present, South Africa's impending hosting of the Soccer World Cup might just provide the incentive needed for success.

Chris Bateman



RURAL DOCTORS GIVEN FRESH HOPE

In a startling speech, the Deputy Minister of Health, Nozizwe Madlala-Routledge slammed 'continued' HIV/AIDS denialism among her political peers and promised rural doctors improved salary packages and service conditions from March next year.

Giving hospital CEOs decision-making powers was a concrete example of government 'making it a priority this year to fill all the posts and determine the correct levels of posts based on workloads'.

Speaking to a record number of 195 delegates at the Rural Doctors Association of South Africa's (Rudasa) 10th annual congress in Empangeni, KwaZulu-Natal on 11 August, Madlala-Routledge also:

- apologised to rural doctors for her department's failure to keep them up to speed on the rural health strategy which Rudasa helped develop
- expressed 'disappointment' that officials from Dr Percy Mahlati's Human Resources department were not present to give feedback and input
- promised to end a situation where some senior clerks were being paid more than health care professionals with 6 or 7 years of experience
- revealed that hospital CEOs will shortly be given increased and wide-ranging decision-making powers, including the advertising of posts
- admitted that all provinces were behind in implementing the new Mental Health Act
- said health deputy director general, Dr Kamy Chetty, in conjunction with the Office for Standards and Health Care Quality in her department, had developed a set of standards for

infection control following dozens of recent high-profile fatalities

- described the reasons behind these cross-infections as 'an emergency' and the current multidrug-resistant TB upsurge where the national average cure rate has dropped to 50% (36% in KZN) as 'a crisis'
- identified the Amatola district in the Nelson Mandela Metro (Eastern Cape), the Ethekwini (Durban) Metro and the Johannesburg Metro as the first targeted areas for her department's national crisis TB management plan.

Deputy Minister's honesty impresses

In a cut-and-thrust health policy session with the rural doctors after her speech, Madlala-Routledge said the absence of Mahlati's officials to answer questions at the meeting was a symptom of understaffing. 'They themselves need help...problems arise because there are not enough people to put together and execute the (human resources) plan.' The government was pinning a lot of hope on the human resources plan. 'But it is still just a plan and until we've implemented it, it remains a plan'.

Giving hospital CEOs decision-making powers was a concrete example of government 'making it a priority this year to fill all the posts and determine the correct levels of posts based on workloads'.

Lead organiser of the conference, Professor Steve Reid of the Centre for Rural Health Studies at the Nelson Mandela Faculty of Health Sciences (Durban campus), said 30% of district hospital medical officer posts were filled in his province.

Madlala-Routledge promised delegates that she would instruct Mahlati to ensure all future developments were shared with them

on Rudasa's e-mail list. Responding to a plea from the newly elected chairperson of Rudasa, Dr Bernard Gaede, she said nurses would be included in this regular e-mail briefing. 'I'm terribly sorry and disappointed that you have no idea where the rural health strategy is. I really am...we'll rectify it,' she said.

Amplifying on the new doctor packages, she said improved uniform conditions of service would mean health care professionals would be able to move from a province to a municipality to a district and enjoy identical improved benefits.

Asked by *Izindaba* to give a specific date by which the new salary packages would be implemented, Madlala-Routledge, replied 'March 2007'.



Deputy Minister of Health, Nozizwe Madlala-Routledge, with incoming Rudasa chairperson, Bernard Gaede.

Picture: Chris Bateman

Here's the money

She emphasised that the Hospital Revitalisation Plan, to which billions of rands have been allocated over the next two financial years, included human resources, working conditions and the retention of staff in rural areas. The directors general of health and treasury had inserted 'specific plans' into the budgetary process and provincial governments would have to identify posts and the 'funds must then just come through'.



'There's been a very important shift in Treasury and we're looking at shortages of staff in health – we're saying to treasury, these are our requirements'. She conceded however that 'it's not as if we have an army of health professionals waiting for us to recruit them'.

Joint teams of provincial and national officials were now conducting on-site inter-modal meetings to ensure quicker infrastructural delivery. A dramatic example of this and the health care delivery dilemma was witnessed by *Izindaba* at Hlabisa Hospital near the Hhluhluwe/Umfolozzi Game Reserve.

Paradise with few to play in it

Here seven of the required 23 medical officers enjoy brand new squash, tennis and basket ball courts and live in smart new fully equipped two-bedroomed flats. Alongside are equally impressive new nurses' quarters.

A Presidential Lead Project, the improved complex centres on a 340-bed hospital serving 240 000 people, with

staff seeing 8 500 patients per month at the 16 clinics scattered throughout the region. The three community service doctors cannot afford to attend the clinics because they're needed to help out their two chief medical officers and two senior medical officers at the hospital itself.

'There is not a single high-profile politician who's admitted they have HIV, and we know some of them are (HIV-positive),' he said, adding that he was not 'outing them but taking exception to these self-same people talking about compulsory notification'.

Dr Francois Venter, president of the HIV Clinicians Society, told the conference that South Africa was facing a 'crisis of health care provision scale', and a 'crisis of prevention scale', in which half of all South Africans would eventually be HIV-positive.

Despite a 14-fold increase in condom use between 1997 and 2004 and a wide knowledge of the transmission process, 65% of people interviewed in a recent survey said they were not indulging in any risk factors.

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Taking the podium after Venter, Madlala-Routledge saluted his contribution, and began by saying, 'What disturbs me greatly inasmuch as we say people are aware of HIV, is the continuing denialism among our people and some of our political leaders'. She ended her speech saying, 'the time for denialism is over'.

Chris Bateman



GOVT 'SPINNING' NATURAL HIV PREVALENCE CURVE

Public health experts have warned the government that its current public relations 'statistical spin', claiming success for its HIV prevention efforts instead of concentrating more on treatment, could return to haunt it.

The national health department has characteristically pointed to the flattening 'curve' in annual HIV prevalence statistics as justification for its emphasis on HIV prevention and healthy lifestyles. Concurrently it has entertained scientifically dubious alternatives and displayed highly controversial historical reluctance to both the prevention of mother-to-child infection and the rollout of ARVs.

In its latest national HIV and syphilis prevalence survey (2005), released onto the national health department website with little public fanfare on 28 July this year, Health Minister Tshabalala-Msimang repeats this pattern in her foreword. She alludes to the treatment of HIV/AIDS just once.

Her department is on record as saying that studies so far had begun to show that intervention programmes that emphasised prevention 'have a very important role in moderating HIV prevalence and the epidemiology of HIV infections in general'.

The government report puts last year's overall antenatal clinic prevalence at 30.2% (up from 29.5% in 2004 and 27.9% in 2003). It then blandly observes that 'HIV prevalence estimates show that HIV is still an important public health area'.

Discussion of the figures fails to allude to the alarming prevalence or discuss more effective reduction strategies. Instead, it observes that when the prevalence estimates are looked at over a 6-year period, 'there is evidence of a minor increase' (from 24.5% in 2001) and comments that 'this is not unusual for a stabilising epidemic'.

While public health experts and epidemiologists agreed that the epidemic was 'reaching a broad peak over a few years', and that this indicated an impending decline, they stressed that this occurred naturally. David Bourne of UCT's School of Public Health, said linking this causally to the government's HIV prevention campaign was 'pure spin doctoring'.

'They could end up being hoist with their own petard if they continue touting their highly flawed argument,' he observed.

'By the survey's own admission, there are 5.45 million people currently infected by HIV – that shows a singular failure of prevention.' He warned that as the ARV rollout progressed it would become 'more and more difficult' for government to use statistics to claim success in prevention. This was simply because HIV prevalence would increase as more people lived longer by using ARV drugs. In addition, there was evidence that the number of people dying was now matching the number of people with new infections, hence the apparent stabilisation of prevalence. 'They could end up being hoist with their own petard if they continue touting their highly flawed argument,' he observed.

Hit early and hard or have minimal impact

He and several others canvassed by *Izindaba* said that unless viral pandemics were 'hit hard' with prevention strategies at their very early stages, it was exceedingly difficult to influence their subsequent course.

Peter Babcock-Walters, Director of the Mobile Task Team based at the Health Economics and HIV/AIDS Research Division at the University of KwaZulu-

Natal, said it seemed 'as if we're treating some of the worst infection rates in the world as a routine and not terribly dramatic public health issue'.

He said rising provincial HIV/AIDS prevalence figures in the report 'quite clearly show that we can't take refuge in the notion that the national figure of 30% is some sort of magical ceiling'.

HIV/AIDS disabling government capacity

Research by his unit published on the website of KZN Premier S'bu Ndebele, shows that 83% of 12 KZN government departments canvassed believed HIV/AIDS was having an effect on planned sector activities and their ability to operate effectively.

Three (unidentified) departments put the degree to which they perceived HIV/AIDS to have negatively impacted on their operational capacity at between 35% and 50% while another three put this figure at between 10% and 25%.



Dr Debbie Bradshaw, Director of the Burden of Disease Research Unit at the Medical Research Council.

Picture: Chris Bateman

The most surprising section in the national government report comes with what it says a graph of the syphilis prevalence trend, by age group, represents. While the graph clearly shows a rise in syphilis prevalence percentages across every age group, the caption reads, 'Figure 6 shows a



decrease in prevalence between 2004 and 2005 in all age groups'. Syphilis is a marker of sexually transmitted diseases.

Dr Debbie Bradshaw, Director of the Burden of Disease Research Unit at the Medical Research Council said this 'clearly has to be a typo. They know that it's gone up, so this is clearly a mistake,' she said.

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Asked to comment on the report, Bradshaw expressed alarm at 15.9% of women under 20 years old attending antenatal clinics being HIV-positive last year. This is a small drop from 16.1% in 2004 but marginally up on the 15.8% figure for 2003. 'This is where we'd expect prevalence to slow down if we were having an impact as these women are probably the most vulnerable to HIV – but there are no signs of this,' she warned.

Another top researcher, who declined to be named for fear of political backlash from his employers, said the report seemed to be saying, 'this is great, we're stabilising'.

'But that's just not enough. There are strong indications that prevention is just not adequate, either now or in the past.'

Manto turning a blind eye

'The minister should be highlighting how high the prevalence is and pointing to concerns about the slowing down of the epidemic,' he added.

The antenatal clinic figures (for 2003, 2004 and 2005) show prevalence among women aged 20 - 24 stable at 30.3%, 30.8% and 30.6%. However, prevalence increased over the 3 years among the older groupings. Women aged 25 - 29 exhibit the highest prevalence at 35.4%, 38.5% and 39.5% while those aged 30 - 34 increased from 30.9% to 34.4% to 36.4%.

HIV prevalence among women aged 35 - 39 is lower but still increased over the 3 years from 23.4% through 24.5% to 28%. The > 40 age group is lower still but also rose over the same time period from 15.8% to 17.5% to 19.8%.

Bourne and Babcock-Walters agreed that what was most needed was for government to start obtaining HIV incidence figures. While Bourne conceded that this was 'technically difficult and cutting edge', he said government had a duty to promote the



Professor Peter Babcock-Walters – head of HEARD's Mobile Task Team on AIDS.
Picture: Chris Bateman

most valuable scientific data possible. Babcock-Walters said incidence research was 'done very effectively in the education sector last year'.

Professor Jerry Coovadia, Victor Daitz Professor of HIV/AIDS Research at the University of KwaZulu-Natal and recipient of the Nelson Mandela Award for Health and Human Rights, responded 'this is a sorry tale of false and misleading optimism based on a particularly tendentious reading of the prevalence figures'.

An estimated 18% of those people calculated to be in need of ART are being catered for since the HAART rollout began 3 years ago.

Chris Bateman