

**They Call It "Patient Selection" in Khayelitsha:
The Experience of Médecins Sans Frontières - South Africa in "Enrolling" Patients
to Receive Anti-retroviral Therapy for HIV/AIDS**

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Abstract

This article explores some of the medical and ethical issues that surround the selection of persons to receive anti-retroviral therapy (ARV) for HIV-AIDS. It is empirically grounded in the experiences of the project to prevent and treat AIDS conducted by Médecins Sans Frontières (MSF) in Khayelitsha, a densely populated, highly disadvantaged, urban township on the periphery of Cape Town, South Africa. The article describes and analyzes the so-called “selection process” that the project’s staff uses to determine which patients to start on ARV therapy; the medical, social, and adherence criteria on which they try to base their decisions; the emotional and moral strains that this entails for them; and their overall reluctance to refuse anyone for treatment. It depicts the evolution that the process has undergone as it has moved progressively toward becoming a system to prepare patients for treatment and help them to adhere to the drug regimen, rather than to select or de-select them. The article ends with brief reflections on the macro-implications of the Khayelitsha project’s experiences in grappling with these issues for dealing with them nationally, in South Africa, the country with the world’s largest number of HIV-positive persons.

Introduction: Underlying Assumptions and Questions

This paper explores some of the medical and ethical issues that surround the selection of persons to receive treatment for HIV/AIDS with anti-retroviral therapy (ARV), and the complex, often troubling process that making such decisions involves. It is empirically grounded in the evolving experiences of the project to prevent and treat HIV/AIDS that operates under the auspices of Médecins Sans Frontières (MSF) in Khayelitsha, a township in the Western Cape of South Africa, located 30 kilometers from the center of Cape Town.

Underlying the observations and reflections upon them that we report is our ethical assumption that access to AIDS treatment is a human right and that ideally, it should be guided by principles of fairness and equity.

Fundamental to considerations of “patient selection,” in our view, is a cluster of interrelated medical, motivational, and ethical questions: When should patients be started on ARV treatment? Can and should it be ascertained in advance of initiating this therapy whether patients will prove to be willing and able to take the ARV medications regularly, in order to produce long-term viral suppression, and minimize the risk of the development of drug resistance? Can patients be helped to adhere to the treatment? If so, in what ways? And to what extent should the health care team be responsible for fostering this adherence?

We recognize that prioritizing patients for treatment, along with treatment for patients, is not unique to HIV/AIDS. Rather, it is common in the practice of medicine – especially in the delivery of care for serious, prolonged, chronic diseases, particularly in the face of problems of scarce, medically relevant resources, and their allocation. But, in

our opinion, because HIV/AIDS is an ultimately fatal infectious disease that has reached global pandemic proportions, and its public health as well as its clinical management is affected by the behavior both of those who receive treatment and those who do not, setting priorities for the groups or categories of people who will have access to therapy takes on added significance.

This article rests on one other set of assumptions. We feel strongly that what is termed in medical and public health literature “scaling up” access to ARV therapy for HIV/AIDS is urgent, on a country-by-country basis, and internationally, with the goal of progressively achieving universal access to treatment for all persons who might benefit from it. However, since this goal cannot be realized instantaneously, but will necessarily entail an incremental process of some duration, for a period of years to come “scaling up” will not dispel issues of patient selection, as we shall briefly discuss in the concluding section of this article.

The MSF Khayelitsha Project

Since May 2001, MSF has been providing anti-retroviral treatment for persons with HIV/AIDS who reside in the township of Khayelitsha. This program, which is carried out in the HIV/AIDS clinics that MSF has established in each of Khayelitsha’s three community centers, has become an integral part of the project that MSF launched in 1999 to explore and demonstrate the medical and economic, and the social and cultural feasibility of preventing and treating HIV/AIDS in a so-called “resource-poor,” economically and socially disadvantaged setting. MSF’s decision to include ARV therapy in its project was made in agreement with the Western Cape Provincial Department of

Health; and in February 2002, it moved from its pilot status to become a fully institutionalized part of the overall MSF project.ⁱ

Khayelitsha is an enclave of some 500,000 inhabitants, most of whom live in corrugated-iron shacks, without running water or electricity. Unemployment is soaringly high; crime and violence (including robbery, domestic violence, rape, and murder) are rampant. The general prevalence of HIV/AIDS is also very high – 26%, measured among pregnant women. The tuberculosis incidence rate is one of the world's highest for open-space sites (1380/100,00). TB/HIV co-infection is very high as well: 63% of the persons with TB are infected with HIV.

In a microcosmic, highly concentrated and accentuated way, these data reflect the epidemic proportions of HIV/AIDS in South Africa. Out of a national population of some 45.5 million people, there are as many as 5,200,000 persons who are currently HIV-positive -- more than in any other country. In 2004, 311,000 persons died of HIV/AIDS-related diseases (almost 900 every day).

The treatment component of the MSF Khayelitsha project is centered around the deployment of first-line, high-acting, anti-retroviral drugs (HAART), in a three-drug regimen of Stavudine or AZT, Lamivudine, and Nevirapine or, in the case of persons with concomitant tuberculosis, Efavirenz. Mainly high quality, relatively low-cost, generic forms of these drugs are used.ⁱⁱ

The aim of this triple therapy is to arrest the progression of the disease by keeping the viral load low enough to enable the symptoms of this ultimately fatal disease to be managed, so that the persons afflicted with it can meet the demands of everyday living for as long as possible, and their survival time will be extended. Once this

treatment is begun it entails the faithful, continuous taking of the medications for the rest of a patient's life. The daily pill burden varies according to the regimen, but in a country like South Africa, where fixed dose combinations are not yet available, it involves taking 4 to 7 pills a day. If the individual with AIDS fails to take the drug regularly, the HIV virus which "learns quickly," will multiply rapidly, develop ways of escaping the treatment forever, and the patient will swiftly succumb to the disease. If such a person is not practicing "safe sex," there is the public health danger that he/she may transmit this drug-resistant form of the virus to others.

At present, 8,000 persons with HIV/AIDS are being treated in the three MSF clinics. 1,500 of these patients are currently receiving ARV therapy, including 100 children. Two permanent physicians are assigned to each clinic. These physicians, along with two to three nurses and three counselors, make up the team in attendance at every clinic session. Physicians deal primarily with patients in advanced clinical stages of the disease, who are not yet receiving ARV medication. Because these individuals are desperately ill, and susceptible to severe, recurrent, opportunistic infections, it is felt that the expertise of a physician is needed to handle the intricate, life-threatening complications that their situation presents. Nurses are the cornerstone of the clinic work, taking responsibility for most of the continuing and follow-up care of both ARV and non-ARV patients. However, physicians manage the serious side-effects of the ARV medications, and problems of resistance to the drugs that may occur. The counselors' work focuses mainly on preparing patients for ARV therapy, furthering their understanding of the disease and its treatment, promoting their adherence to the drug regimen, and involving them in support groups,

One of the Khayelitsha project's most distinctive characteristics is that, without becoming politicized, it has been collaborating with the Treatment Action Campaign (TAC), an HIV/AIDS-dedicated, South African civic organization that developed out of the tradition of the antiapartheid movement. TAC has led a powerful struggle to raise local and national consciousness about the HIV/AIDS epidemic, advance openness about it, reduce the stigma associated with it, implement educational programs to lower its incidence, prevent its transmission, develop "treatment literacy," and put the Government under pressure to enact a national HIV/AIDS prevention and treatment program that includes anti-retroviral therapy for all people in South Africa who need it.

The "Patient Selection" Process and Its Evolution

This is the framework within which the Khayelitsha project has grappled since its inception with what it considers to be one of the most difficult and disturbing problems that it faces – namely, how to decide which patients to start on ARV therapy, and when to do so, using criteria for these decisions that are both medically sound and ethically just. The fact that MSF is a movement and an organization that operates within a culture of inquiry and debate about its medical humanitarian and human rights witnessing action, has contributed to the staff's continuous concern and discussion about what they refer to as this problem of "patient selection." However, as our descriptive analysis of the decision-making process in which they actually engage will reveal, there is a fundamental sense in which the term "selection" is a misnomer.

In the earliest days of the Khayelitsha project, when it was totally supported by MSF and had only enough funding to treat 180 patients with ARV therapy, it used what its personnel experienced as a dismaying process of drastic selection based on a "priority

scoring system.” Priority scores were rapidly abandoned at the end of 2003 when MSF committed sufficient funds to the Khayelitsha undertaking to make treatment for 400 persons possible.ⁱⁱⁱ It was at this juncture that the project established a so-called “selection” committee, composed of clinical staff members. The committee was centrally run, met once a month, and strove to attain impartiality in the decisions it made, through abiding by norms of strict anonymity and transparency, and the participation of a large community representation in its proceedings. Their decisions concerned starting patients on anti-retroviral therapy, based on an ensemble of medical, social, and what were called “adherence” criteria. The latter consisted of criteria that were considered to be indicators that patients provided with ARV therapy would take the medication faithfully and regularly.

On November 19, 2003, the Department of Health of the South African government approved a long-awaited Operational Plan for Comprehensive Treatment and Care for HIV and AIDS that set into motion a political process to progressively make free anti-retroviral medication available to all citizens of the country with HIV/AIDS.^{iv} This national “roll-out” development unlocked international funding mechanisms, with the result that since July 1, 2004, 80% of Khayelitsha’s financial support comes from the Global Fund to Fight AIDS, Tuberculosis and Malaria (which it receives via the Western Cape Provincial Government), and 20% from MSF. As a consequence, money is no longer a bottleneck for the Khayelitsha project, which now has sufficient financial resources to enroll as many persons with HIV/AIDS in the township for ARV treatment as they deem they can handle. Financially, the project is moving closer to assuring

universal coverage in Khayelitsha; and in the course of 2005, it hopes to be able to meet 100% of the pediatric and 50% of the adult needs for treatment.

At present, it is shortage of staff rather than restrictions in funding that limits the number of patients the project feels it can enroll for treatment. Although public health salaries in South Africa are ample enough to have attracted medical and nursing personnel from neighboring countries, South African physicians and nurses have been emigrating in sizable numbers to societies such as the United Kingdom, Canada, Australia, and the United States, where they can expect to earn higher incomes. The HIV virus is also contributing to the dearth of available health professionals, many of whom have been stricken with AIDS.^y

This deterrent notwithstanding, the significant increase in funding has enabled Khayelitsha to considerably expand its patient enrollment (from an average of 32 new patients per month in 2003, to 97.5 a month in 2004); and it has led them to alter the organization of its selection committee and its procedure. Instead of one central selection committee for the entire Khayelitsha site that formerly existed, what is still called a selection committee has been established in each of the three HIV clinics. These committees meet fortnightly; are mainly composed of, and managed by clinical staff; and also include one patient in its membership who is defined as an “external witness.”

At the meetings of the selection committees, a clinical nurse presents patient-candidates who are regarded by the staff as potentially qualified to be put on ARV therapy, and most urgently in need of receiving it. A set of medical, social, and adherence criteria are used to arrive at this evaluation. Medically, the patient must have undergone two tests that confirm his/her HIV serostatus, and should be in what the World Health

Organization designates as stage 4 of the disease, or in stage 1, 2, or 3, if the patient's CD4 count is <200 cells/mm³. Tuberculosis is considered a medical contraindication for initiating ART unless the patient's CD4 count is < 200 cells/mm³. The social criteria include a record of regular clinic attendance by the patient (at least four scheduled visits to the HIV clinic); the patient's commitment to staying in Khayelitsha for at least six months, to long-term anti-retroviral therapy, and to safe sex practices ("condomizing," or abstaining from sexual relations); the willingness of the patient to disclose his/her HIV status to a person in their confidence (older than 18 years of age), who also agrees to act as the patient's treatment assistant; and readiness to attend a support group for persons on ARV therapy for at least once a month during the first year of treatment. Alcohol or other substance abuse, and untreated active depression are regarded as social contraindications for initiating ARV therapy. The main adherence criteria consist of the patient's presentation on time to the last four medical consultations ("on time" is liberally defined as on the day of the scheduled clinic visit); attendance at a minimum of three intensive counseling sessions; and agreement to a preliminary home visit by a counselor or nurse to discuss the treatment with the patient and the treatment assistant, if there is uncertainty concerning his/her ability to meet any of the criteria.^{vi} In principle, fulfillment of *all* medical, social, and adherence criteria is required for beginning ARV therapy.

The primary data reported by the clinical nurse at selection committee meetings are medically relevant facts concerning the patients under consideration: their date of birth, gender, the date when they were first seen in the clinic and diagnosed as HIV-positive, the number of visits they have made to the clinic, their CD4 count, the stage of the disease they are in, what opportunistic infections they have had, and whether they

have a concomitant diagnosis of tuberculosis. The physician (or physicians) participating in the meetings focus on the medical (biological and clinical) criteria, and on what is euphemistically called patient “fitness” to begin ARV therapy. The latter chiefly refers to the program’s inclination to exclude patients with active tuberculosis, because of the high probability that after the initiation of ARV treatment such patients will develop an immune reconstitution that will cause their clinical status to worsen. Counselors have the final word in the decisions taken regarding when the treatment should begin; and they are responsible and accountable for long-term patient adherence.

On the average, some 30 to 40 patient-candidates are reviewed by each clinic, each month.

Reluctance to Refuse Anyone for ARV Treatment

Despite the elaborate, well thought-out set of criteria that presumably guide the selection committees’ appraisal of patients’ suitability to receive ARV therapy, the most striking result of their deliberations is that in almost every instance, the decision is taken to “accept” the patient for treatment. When it is reported that a candidate slated to begin the therapy has not met certain of the social and adherence criteria – such as readiness to use condoms, the punctual keeping of clinic appointments, regular participation in a support group, or disclosure of HIV/AIDS status – the tendency is still to admit the person into the ARV program. The staff views meeting these criteria and abiding by them, dynamically, as conditions that patients can be helped to fulfill -- both before and after the initiation of treatment -- with the help of counselors, and of fellow-patients. “Preparing” patients for treatment, as this process is called, has become so predominant

that, with humor-tinged seriousness, some staff members have suggested that the “selection” committees ought to be renamed “patient readiness” committees.

“We never definitely give a ‘no’ to any patient for ARV,” one of the MSF physicians declared. “This is felt to be unethical. We just say, ‘Not ready.’” The closest that they come to turning a patient down, he contended, was illustrated by a case in which the period of “temporary refusal of ARV treatment” was so prolonged that “when we finally gave the green light [to start it], it was too late”:

X was a 26 year-old woman, with HIV/AIDS, who was living alone with her 16 year-old daughter. She had also developed pulmonary tuberculosis, and was not able to adhere to the course of treatment for it. The decision was made to send her to the local hospice run by the Order of Mother Teresa’s Sisters (the Missionaries of Charity), where she could receive supervised TB therapy. She improved dramatically under their care. She insisted on being discharged from the hospice before the Khayelitsha team could start her on ARV medications, and then disappeared from their view. Three months later, she returned to Khayelitsha, and was seen in one of the HIV/AIDS clinics, where she was found to be in an emaciated state, with a very large ulcerated herpes zoster, and urgently in need of ARV treatment. Because of her previous record of irregularity in keeping appointments, and her non-adherence to TB therapy, it was decided that her ARV treatment would have to be carried out under supervision, and that she should be readmitted to the hospice for this purpose. It took her a long while to accept these conditions, and when she finally did, she was in the terminal stage of HIV/AIDS.

She was immediately started on ARV therapy, but she died in the hospice a few weeks later.

The Khayelitsha team finds it difficult to accept the possibility that certain patients may never be able to reach or maintain the “preparedness” level to receive ARV treatment required by the social and adherence criteria, despite all the coaching and support they receive, and that under these circumstances, ARV therapy should not be started in the first place or, if a patient is already receiving the therapy, the decision should be made to withdraw it:

L., a 32 year-old, male patient, was among the first to be enrolled in the Khayelitsha ARV program. Although the selection committee was aware of the fact that he was violent with his girlfriend, and that he abused alcohol, they believed that he would be able to turn his life around and stabilize it. Their confidence in his capacity to do so was based on their admiration for his dedicated involvement in the Treatment Action Campaign (TAC). L. had organized a TAC branch close to his home, and worked committedly to promote access to treatment for HIV/AIDS. However, he was never able to find regular paid employment.

Shortly after starting ARV treatment, L. ceased to adhere to the mandatory drug regimen. Subsequently, the clinic staff learned that this was due to the fact that he had been hospitalized for a broken arm caused by a gunshot wound. Therapy was rapidly resumed, and he improved significantly; but after six months of therapy, his non-adherence to treatment became manifest. His CD4 count was

barely improving, and his viral load remained detectable at three- and six-month routine checkups. Shortly after nine months on ARV medications, his clinical status worsened, and he developed pulmonary tuberculosis. He was urged by the staff to attend intensive counseling sessions, which he did. He improved once more for a short while, but “defaulted” again in the taking of his medications, and vanished from sight. When he reappeared, his clinical status had deteriorated still further. At this point, the Khayelitsha team painfully decided to withdraw ARV treatment, not only because the clinical signs indicated that it was not benefiting him any more, but also because they hoped that this would produce a “reality shock” that would forcefully remind him about the importance of “regularity” and “adherence.”

Their strategy did not work. L. died from disseminated tuberculosis, 18 months after he had received his first dose of anti-retroviral drugs.

One could say that virtually until the day that L. died, the staff did not relinquish their intention of finding a way to maintain him on ARV therapy. In their eyes, his was a “tragic history.” His way of life, and the “competing priorities” in it, they felt, grew out of his enormous personal frustration over his unemployment, and his consequent inability to “put bread on the table,” and fulfill other traditional obligations of a Xhosa-African man (a predicament that pervades the lives of the male inhabitants of Khayelitsha.) Although he tried to cope with his frustration through his HIV/AIDS-focused political activism, he never succeeded in sufficiently “overcoming his demons,” as one physician put it, “to achieve regularity in treatment.” There is a sense in which the

staff's understanding of L.'s social, economic, and cultural situation, and his reactions to it made it harder for all of them to take the decision that they did. In the end, however, it was the doctor in charge of the case who was the most emotionally and ethically disturbed by the outcome. Although he regarded the withdrawal of ARV therapy as clinically justified, he felt a sense of responsibility and of failure over the fact that this decision "did not offer any future to a charismatic patient." The chief counselor who was involved in the case found some consolation, as well as justification, in the fact that according to the criteria of patient adherence, which it was her professional obligation to monitor, the decision to stop treatment was the "right one".

Reluctance to Accept Patients' Refusal to Begin Or Continue ARV Treatment

The medical staff is also averse to passively agreeing to the disinclination of some patients to start, or continue ARV therapy:

A., a terminally ill, 34 year-old man, with a CD4 count of 9, in Stage 4 of HIV/AIDS, was described in a selection committee meeting as having displayed "repeated adherence problems" in the past. He had failed to show up for clinic appointments, and at one point had "disappeared" from Khayelitsha, when he returned to the Eastern Cape, his region of origin, for a prolonged period of time. It was reported in the meeting that A. had vocally objected to the fact that family members – particularly his aunt, who was his devoted caretaker – were "forcing" him to seek treatment. The committee engaged in more discussion about this patient than usual, especially because A.'s aunt strongly advocated that he receive treatment, but his HIV/AIDS had progressed so far that he was no longer "responding," and able to give his own informed consent for it. Although the

physician presenting A.'s case stated that "even if we start him now [on therapy], he is likely to die in a month," the committee decided to immediately begin treating him with ARV drugs, and to monitor his case on a weekly basis.

S., a 31 year-old taxi driver, was sent to the Khayelitsha HIV/AIDS clinics by the GF Jooste Hospital, the project's referral hospital. He had been diagnosed with cryptococcal meningitis, and was in Stage 4 of HIV/AIDS. His wife and five year-old son were also HIV positive. Because of the clinical stage of his disease, he was rapidly selected as a candidate for ARV medications. However, he refused to start treatment for several months, insisting that he wanted his wife to become pregnant before he began the therapy. Having sexual intercourse with his wife without using a condom contravened the safe sex policy to which patients being cared for in the program were expected to adhere.

S.'s wife, who was well informed about HIV issues, was started on ARV's. Two months later, she became pregnant. Once this occurred, S. stated that he was now ready for ARV therapy, and his treatment was begun. His wife then underwent an abortion, claiming that ARV drugs had toxic effects on a pregnancy. Subsequently, both she and her husband stopped taking the ARV medications.

Their current whereabouts are unknown to the Khayelitsha staff – but were they to appear again, it is not inconceivable that the decision would be made to resume their ARV treatment.

Sources and Persistence of “Patient Selection” and “De-selection” Issues

The unwillingness of the selection committees to outrightly refuse anyone for ARV treatment, their conviction that to say “no” unconditionally and definitively is unethical, the suasion and support that they marshal to get and keep patients on the regimen, and their tendency to find extenuating reasons to explain and override indications that a patient has not met the selection criteria, continued to fulfill them, or wishes to stop the treatment, stem from a number of sources. Above all, there is their shared belief in the restorative powers of ARV therapy, and their commitment to the mission of giving every patient with HIV/AIDS “a chance,” by making the treatment available to all who might benefit from it. Furthermore, they are concerned about insuring that they do not end up acting as a judgmental “tribunal,” making life-or-death decisions in the process of trying to ascertain which patients will, and which will not do well on ARV therapy. This is particularly apparent when they are confronted with patients in a very advanced, rapidly evolving stage of HIV/AIDS, who have a high risk of imminent death. In such instances, when the medical staff, along with the selection committees are brought face-to-face with the fearsome question of how to decide, “Who shall live when not all can live?”^{vii}, they are inclined to allow these persons to “jump the queue” of what are usually some 500 patients with CD4 counts of less than 200/ml who are waiting to begin ARV therapy. They do so with the uncomfortable knowledge that such “fast-tracked” patients will not only delay the treatment of other patient-candidates who may have been waiting longer, but may also contribute to the further deterioration of their immune function because of the extended waiting time.

The difficulty that the members of the Khayelitsha selection committees have in cleaving to the formal criteria that they have devised for determining if and when a patient is ready to start ARV therapy, and in denying any patient the opportunity to receive it, calls to mind for one of us (RCF) comparable problems that the Admissions and Policy Committee of the Artificial Kidney Center in Seattle, Washington, USA experienced during the 1960s. This committee was confronted with the task of screening and selecting patients with end-stage renal disease for chronic intermittent hemodialysis, in an era when the limited number of kidney machines and financial resources available for this purpose made it impossible to accept every patient who was potentially medically eligible to receive the treatment. The committee drew up a number of social and psychological, as well as medical criteria for selecting which patients were given access to this life-prolonging therapeutic procedure. Nevertheless, like their Khayelitsha counterparts, committee members were disinclined to strictly apply them to their decision-making. It was striking to observe how few of the selection/de-selection criteria that they were supposedly utilizing ended up disqualifying a candidate for the procedure. In effect, in common with the Khayelitsha committees, the Seattle committee was oriented to selecting, rather than refusing the patients whose cases came before them.^{viii}

It might be supposed that the issues surrounding patient selection for ARV treatment, and the clinical and moral dilemmas and emotional strains that they pose for health care workers would be dispelled by changes in economic, political, and social conditions that made these drugs available to all who need them. However, some of the consequences of the financial “democratization” of dialysis in the United States are instructive in this regard because they suggest that this may not be the case, and that more

than the problem of scarce funds and therapies and their allocation are involved.^{ix} In 1972, the U.S. Congress passed a law that, under Social Security, extended Medicare coverage insurance for the treatment of end-stage renal disease by dialysis and/or kidney transplantation to almost the entire American population.^x But the unease that physicians had previously felt about “playing God” in their role as gatekeepers of dialysis was not done away with by universal financial accessibility to this treatment; and in certain respects, it was replaced by new sources of disquietude. The major issue that physicians now faced was that with payment guaranteed, using biological and clinical, as well as psychological and social criteria of patient selection became so questionable that they felt there was now virtually no way to turn anyone with end-stage renal disease down for dialysis that would be considered either medically or morally defensible. What some nephrologists referred to as the “de-selection” of patients for this mode of treatment because it would not benefit them, would subject them to a dubious quality of life, or even (as Belding Scribner, the inventor of chronic intermittent dialysis put it) entail “a fate worse than death” for them, became acutely problematic.

“Scaling Up” and Selection

The so-called “universal roll-out” of ARV therapy for all who need it has only begun in South Africa, and the country is still far from dealing with, or even anticipating what patient selection and de-selection issues achieving that goal might entail. But the process of “scaling up” ARV treatment that has been launched, already makes it apparent that the problems of selecting patients for ARV therapy with which the MSF project has been struggling in the microcosm of Khayelitsha will not only persist for some time to come, but may even be amplified in certain ways.

Expanding AIDS treatment on a national scale is an intricate and ramifying public health challenge. A distributive ethic, oriented to the greatest number of persons in all regions, communities, economic, social, and cultural groups in the country, rather than to an individual ethic that gives precedence to the well-being of each patient in a one-on-one relationship to health care professionals, will have to prevail. It is likely to be accompanied by areas of tension between them. The South African government's Operational Plan for Comprehensive Treatment and Care for HIV and AIDS will need to be phased in incrementally, bringing in its wake questions about the order in which treatment centers will be established in the different districts of the country, and the priority and provisions assigned to them. The foremost hindrance to the full implementation of this plan is the dearth of physicians and nurses to treat and care for all the persons with HIV/AIDS in the population, rather than insufficient funds or supplies of affordable ARV drugs.^{xi} What is more, expanding ARV treatment on a society-wide scale will probably require major changes in the entire South African health care system, whose current status is described by professor of medicine Solomon R. Benatar in the following way:^{xii}

Considerable legislation has been passed with a view to achieving greater equity in access to healthcare with a district-based primary health care system. To achieve this, national public health resource allocation is focused on redistribution away from tertiary care towards primary health and community-based care. However, excessively rapid transformation toward these goals has resulted in dysfunctional primary services and attrition of tertiary services in the public

sector with greater losses than gains in healthcare in the short term and adverse implications for the future.

Within this already burdened system of health care delivery, major issues of how to allocate its personnel, facilities, and energies between the treatment and care of persons with HIV/AIDS, and all the other health and medical problems of the country's citizenry will arise, and require developmental solutions.

It is the hope of the MSF Khayelitsha program that what they have learned on a local scale from their first-hand experience in dealing with medical and ethical issues of what they call "patient selection" can make a constructive and edifying contribution to this at once urgent and formidable societal process.

ⁱ The first MSF mission to incorporate anti-retroviral therapy into its HIV-AIDS-oriented medical program was undertaken in Bangkok. The project in Khayelitsha was the second one, and MSF's first in Africa. At present, 55 such MSF programs exist in 27 countries, which treat a total of more than 23,000 patients.

Initially, the Khayelitsha program was mainly supported by private funds from different MSF sections, Belgian and Danish Cooperation funds, and the Letten Foundation in Norway, and with funds from the Provincial Government of the Western Cape.

Building on their Khayelitsha experience in a highly disadvantaged urban township, in 2003, MSF South Africa, with the help of financial and moral support from the Nelson Mandela Foundation, inaugurated a program to prevent and treat HIV/AIDS in a remote, impoverished rural milieu in the Eastern Cape of South Africa (Lusikisiki). Lusikisiki suffers from the kind of poor health infrastructure and scarcity of health staff that is common to such distant rural areas in Africa, and that makes the effective implementation of HIV/AIDS services – especially in the face of the adult prevalence rate between 30% and 35% with which it is confronted – a daunting challenge. Nevertheless, the program managed to start 500 patients on ARV therapy during its first year of existence.

ⁱⁱ Originally, these drugs were mainly imported from a state-controlled Brazilian company, but at present, they are chiefly supplied by Indian companies; and most recently, the first-line, three drug regimen has been offered to public services for \$15 U.S. dollars per month by Aspen Pharmacare of South Africa. Aspen, based in Johannesburg, is the largest drug company in Africa. It has the permission of GlaxoSmith Kline and of Boehringer-Ingelheim to make generic versions for the South African market of the AIDS drugs on which these pharmaceutical firms have patents.

ⁱⁱⁱ In 2004, MSF increased its funding once more, making it possible to cover the costs of offering ARV treatment to 600 persons.

^{iv} The implementation of this planned program has been slow. No more than 65,000 persons out of the more than 500,000 individuals in the country who need anti-retroviral therapy immediately to stay alive are currently receiving it.

^v The program that MSF created in Lusikisiki, in a very poor and isolated area of the Eastern Cape, is having much more difficulty in recruiting physicians and nurses than Khayelitsha.

^{vi} In an earlier phase of the Khayelitsha project, when funding and access to ARV drugs were scarcer, a home visit to every prospective recipient of treatment was required. At present, this only takes place if counselors feel that they do not have enough information about a patient's family or residence.

^{vii} Childress JF. Who shall live when not all can live? *Soundings* 1970; 43 (winter): 339-355.

^{viii} Fox RC and Swazey JP *The Courage to Fail: A Social View of Organ Transplants and Dialysis*. Chicago: University of Chicago Press, 1974 and 1978 (second, revised edition), and New Brunswick (USA) and London (UK): Transaction Books, 2002 (republished with a new Introduction). See especially, Chapter 8, "Patient Selection and the Right to Die: Problems Facing Seattle's Kidney Center," pp. 226-265.

^{ix} For a detailed account of some of the unanticipated as well as anticipated consequences of the "democratization of dialysis," see Chapter 11 in Fox and Swazey, *The Courage to Fail*. University of Chicago Press, 1978 (second, revised edition), and Transaction Books, 2002, pp. 345-375.

^x Public Law 92-603 was passed on October 30, 1972.

^{xi} This problem exists throughout the continent of Africa. In a report released on November 26, 2004, the Joint Learning Institute, a research group of some 100 scholars and experts, financed by the Rockefeller Foundation and the Bill and Melinda Gates Foundation among others, stated that Africa needs a million more health workers to deal with the HIV/AIDS pandemic. In this connection, it exhorts rich countries to stem the "fatal flows" of nurses and doctors from poor African countries to Europe and North America. (See Dugger CW. Africa needs a million more health care workers, report says. *New York Times* 2004, 26 November: A27).

^{xii} Benatar S. The lost potential of our health system. *Cape Times* 2005, 14 January.