Health-E

Poor services undermine HIV treatment programme

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April 3, 2013

The state of many public health facilities threatens the expansion of the countrys antiretroviral treatment programme, particularly frequent ARV shortages and poor service delivery.

So argues Professor Francois Venter from the Wits Reproductive Health and HIV Institute in the SA Health Review 2012/13.

Interventions relating to the National Health Insurance system and the establishment of core standards of care for all health facilities will hopefully address these challenges, says Venter.

Everyone with a CD4 count (measure of immunity) of below 350 should be treated as soon as they reach this level for optimal results, instead of when they are sick and it is harder to re-build their immunity. This means regular HIV testing.

At the current rate, over 400 000 new patients a year will need ARVs a situation that will continue for as long as our prevention programmes are not effective, says Venter.

As patients accrue on the programme, the medication budget will increase commensurately. One modelling exercise suggests that the HIV treatment programme will double in cost between 2010 and 2017, says Venter.

At present, staff costs are the highest single cost of the treatment programme and there is an urgent need for the programme to be nurse-driven at a primary level. For example, Helen Joseph Hospital in Johannesburg was treating 30 000 patients on ARVs last year when many of these could be treated at clinic level.

More decentralised models in inner city Johannesburg have successfully demonstrated that primary health clinics can successfully initiate and monitor treatment.

The ARVs of stable patients could also be delivered to their homes to protect them from being exposed to TB and other diseases in hospital waiting rooms.

Five sub-populations are not getting adequate access to HIV treatment teens, foreigners, men who

have sex with men (MSM), sex workers and men. Most teens who need ART were infected with HIV at birth, but their parents have not disclosed their status. They are vulnerable to stunting without proper treatment.

Although foreigners are able to get ART, xenophobia often prevents this, while homophobia is a barrier to men who have sex with men getting treatment. Sex workers are criminalised so access to them is difficult. Finally, over 60% of people on treatment are women. Men access treatment later when they are much sicker, in part because women are more used to going to clinics from pregnancy and because of masculine ideas that equate sickness with weakness.

While government pays for 80% of the countrys treatment programme, donor funding for HIV has declined dramatically, particularly from the US Presidents Emergency Plan for AIDS relief (Pepfar), which is cutting its contribution in half by 2017.

Most Pepfar-funded treatment programmes run by NGOs have had to transfer their patients to government facilities which have been ill-prepared for this influx of patients.

The government, which often deals with multiple stock-outs of drugs, has not provided care at the level that many NGOs have been able to do with focused HIV treatment and care programmes. As a consequence the transition process has been fraught with delays and disturbances in some places, says Venter.

Despite the problems, South Africa has the largest HIV treatment in the world and its success rests largely on the countrys ability to manage complicated policy and operational challenges.

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