Primary clinics the key to treatment

THE STATE of many public health facilities threatens the expansion of the antiretroviral treatment programme, particularly frequent ARV shortages and poor service delivery. This is the argument put forward by Professor Francois Venter of the Wits Reproductive Health and HIV Institute in the SA Health Review 2012/13. He said it was hoped that interventions in terms of National Health Insurance and establishing core standards for all health facilities could deal with these challenges. Everyone with a CD4 count (a 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 rebuild their immunity. This means regular HIV testing. At the current rate, more than 400 000 new patients a year would need ARVs - "a situation that will continue for as long as our prevention programmes are not effective", he said.

Venter said that as patients accrued on the programme, the medication budget would increase commensurately. One modelling exercise suggests that the HIV treatment programme will double in cost between 2010 and 2017. Staff costs are the highest single cost of the treatment programme and there is a 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 primary health clinics, as decentralised models in Johannesburg had shown, Venter said. Five "sub-populations" are not getting adequate access to HIV treatment - teens, foreigners, men who have sex with men, sex workers and men. Most teens who need ARVs were infected with HIV at birth, but their parents have not disclosed their status. Although foreigners are able to get ARVs, xenophobia often prevents this, while homophobia is a barrier to treatment for men having sex with men. Sex workers are criminalised, so access to them is difficult.

Finally, more than 60 percent of people on treatment are women. Men access treatment later when they are much sicker, in part because women are more accustomed to going to clinics from pregnancy and because of masculine ideas that equate sickness with weakness. While the government pays for 80 percent of the treatment, donor funding for HIV has declined dramatically, particularly from the US President's 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 state facilities, which have been "ill-prepared for this influx". The government has not been able to provide the level of care the NGOs have given. Consequently, "the transition process has been fraught with delays and disturbances in some places", Venter said. Despite the problems, South Africa has the largest HIV treatment in the world and its success rests largely on the ability to manage "complicated policy and operational challenges".

Kerry Cullinan: Health-e News Service, 3 April 2013