

HATiP

HIV & AIDS Treatment in Practice

Issue 51 | 14 July 2005



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South African progress report on scale up of HIV treatment and care

South Africa's Comprehensive Plan for the Management of HIV and AIDS

"If we continue at the current rate, it's going to take years and years before we get anywhere near the number of people on [antiretroviral] treatment that we need to," Dr. Francois Venter of the University of the Witwatersrand (Wits) warned the audience on the final day of the 2nd South African AIDS Conference in June. He told conference-goers that the South African HIV treatment programme would have to scale up much more rapidly "to attain the target that we set for ourselves within the department. We need to work harder, faster, better, smarter to make this programme work."

Dr. Venter, Clinical Director of the Esselen Street Project in Johannesburg, has participated in the National and Provincial Department of Health's ARV rollout working groups and supports the Gauteng and North-West Provinces in both training and treatment. He offered conference-goers a progress report on the implementation of South Africa's "Comprehensive Plan for the Management of HIV and AIDS" as well as his insight into some of the challenges to more rapid rollout of antiretrovirals (ARVs).

First though, Dr. Venter took issue with the term 'rollout': "When you talk about diabetes, you don't talk about the insulin 'rollout' — it's a ridiculous concept. And the ARV rollout is a cliché that I hope is going to die away... We're going to talk about the package of care for HIV-infected people which will have all the components [contained in the comprehensive plan]."

"On behalf of all the clinicians here, none of us believe that antiretrovirals are the be all and end all," said Dr. Venter. The comprehensive plan covers management over the entire course of the HIV disease from infection through the 8-10 years (on average) before advanced disease and progression to AIDS — "at which point," said Dr. Venter "we need antiretroviral therapy."

"There are a whole range of interventions that can slow that progression, which includes wellness — nutrition, exercise, stop smoking, safe sex, improving mental health, and decreasing the intake of alcohol. We only introduce the drugs right at the end."

Even so, Dr. Venter believes that antiretrovirals work dramatically well when they are needed: "There are very few interventions in medicine that take someone who is essentially a skeleton and turn them back into being a fully functional, working human being." He presented preliminary data from a few of the treatment sites in South Africa demonstrating that treatment was achieving dramatic CD4 and viral load responses, and that toxicity has been, for the most part, manageable. Dr. Venter thinks these responses will be sustained for quite some time. "Even using just the existing [marketed] drugs, the latest modelling suggests we are looking at more than twenty years [additional lifespan] on this package of care. That means these people will see their grandchildren — it's a major medical miracle — exactly like insulin for diabetes."

"If we provide all the support systems for comprehensive care, we are looking at a group who will grow old with HIV."

Numbers

"At the moment there has been a lot of discussion about the numbers," said Dr. Venter. Indeed, on the opening day of the conference, the Minister of Health Manto Tshabalala-Msimang had told the conference that the treatment programme was "on track," but that she had no reliable figures on the actual delivery of services at the clinic level (at present around 50,000 South Africans are receiving antiretroviral treatment through the public sector).

She took issue with the World Health Organization's (WHO) complaint that South Africa wasn't reaching its share of the 3x5 targets (see

<http://www.aidsmap.com/en/news/77C1AB07-282C-4658-94BB-BD6F3C8BACE8.asp>,

<http://www.aidsmap.com/en/news/545DE501-06E1-4DB8-91E4-14853F0BF7D0.asp>) saying that "we were not consulted" when WHO set its goals. She also made reference to the Treatment Action Campaign (TAC) call to put many more people on treatment by 2006: "I see placards distributed today that people are aiming at 200,000 by 2006 and yet these figures have not been discussed with the Department of Health."

And yet, Dr. Venter pointed out, this very figure had already been set as a target by the Department of Health in its comprehensive plan in October 2003, which noted that 5 million HIV-infected people needed care across the nation and 400-500,000 people needed antiretroviral treatment immediately. Page 79 of the plan says: "the team believes that the 50% ARV scenario is — at least in the early years of implementation — a more realistic forecast of both the likely uptake and of implementation capacity for a national ART programme."

"50% is a realistic target of what we should be shooting for. We need to reassess that target from time to time, [but for now] the plan says that we should try to get half of the people on treatment as soon as possible," said Dr. Venter. But at the current rate of scale up, "it will still take years to reach that 50%, somewhere around 200,000 and 300,000 patients (see Figure 1) — and one of the worrying things is that the monthly rate at which people are initiating antiretrovirals has actually gone down a bit during the last couple of months."

Figure One

Dr. Venter presented the most recent available data on the numbers on treatment by province (see Figure 2) but noted that "looking at absolute numbers in each province isn't really very useful." He believes a better measure would be to look at the ratio of patients on treatment and the patients in need of treatment. Nevertheless, the numbers show that "there are provinces that are not scaling up as quickly as we would like and we really need to figure out why."

Figure Two

Although recently, the Free State has seen a dramatic increase in the number of patients on treatment, in the early days of the rollout in that province, more than half the people who were staged for CD4 count and who qualified for treatment were lost to the programme before starting ART (see Figure 3) "It's a terrible thing," said Dr. Venter "half the people — with upfront staging and when the green light has been given — are not getting into the programme."

Figure Three**Barriers to more rapid scale-up and other threats to the programme****Adherence overkill**

"While I do think we need to prepare patients for treatment, we are seeing adherence overkill especially in some of the rural provinces," said Dr. Venter. He believes that some sites or provinces are getting too hung up on patient-readiness training, in an effort to ensure treatment adherence. Too much of this good thing could be scaring patients off.

During an earlier conference presentation, Dr. Norbert Ndjeka — who delivers ART treatment through a small primary health clinic in Bela Bela, Limpopo — noted that there are also long waiting times for adherence counseling, partly because clinics lack adequate physical space.

The first-wave effect

Dr. Venter also thinks that it isn't realistic to expect the near perfect adherence that has been reported among some of the first African patients who have accessed ART. "One thing I disagree with very strongly is that Africans are better than people in the West at taking drugs. The people who are in the treatment programme at the moment are desperate for therapy — they are the first wave. The real patients are going to be seen in about three or four years time. We are not going to get the same level of adherence from them so I'm worried that we are holding up too high a bar in terms of people staying in the programme and adherence rates. We don't need to expect the same level of adherence — it's just not practical."

The superhuman syndrome

In general Dr. Venter believes that some sites may be setting the bar too high for patients: "The other thing I'm worried about is the superhuman syndrome. Before they are given antiretrovirals, patients are being told that they need to eat properly, stop smoking, disclose their status, exercise, stop drinking and think positively... and all before the next clinic visit. I look at that and I need a drink contemplating it myself. I don't think that stopping people smoking is the priority... it's something that we need to work on as clinicians but it shouldn't be an obstacle to receiving ART."

The R79 clinic access fee in Gauteng Province

Although antiretroviral treatment is free, patients attending hospital clinics in Gauteng (which includes Johannesburg and Pretoria) are required to pay a 79 Rand access fee to the clinic in order to get the antiretrovirals. There is no clinic access fee in other provinces.

"If you make it free," said Dr. Venter "adherence improves."

Human resources

"Human resources are a massive problem. I think one of the biggest problems in some of the provinces is that they are waiting until they have staffing to do this... unfortunately, the people do not exist."

Mpumalanga and Limpopo, in the remote rural Northeast of the country, have been using this as an excuse to delay the rollout. Said Dr. Venter "I know lots of hospitals in Limpopo and Mpumalanga that have trained, committed staff, who haven't been 'authorised' [to use antiretrovirals]." Many people in these provinces also live far

from tertiary hospitals so most treatment will ultimately have to be distributed at the primary healthcare level — which will never have adequate staffing to become fully accredited. According to Dr. Ndjeka's presentation, Limpopo only intends to officially rollout treatment through its primary health clinics in 2008 — even though his clinic has provided a model by successfully treating hundreds of patients in Bela Bela.

According to Dr. Venter, "some of the most successful provinces, are the provinces who said that 'we are never going to get enough people — we've been trying for years before the antiretroviral programme, we're not going to get them now (more below)."

– Lack of pharmacists

Even so, he believes that a lack of qualified pharmacists is a major obstacle for the programme

– Dietitians: false obstacle?

But Dr. Venter believes that some of the human resource challenges are false obstacles, for example, the Comprehensive Plan's requires that each ART site have a dietitian before it is accredited to dispense ART.

"I don't understand this obsession with getting a dietitian," said Dr. Venter. "when — for the diabetes programme — we often have situations where people are given dietary advice by nurses and counsellors who don't necessarily have a dietary degree."

– Retaining nurses

Dr. Venter quoted Dr. Herman Reuter, head of Medecin Sans Frontier's project in Lusikisiki, Eastern Cape. "What do we need to do to retain nurses in Lusikisiki? Build a city."

Unfortunately, there are some areas of the country where it is difficult to lure and retain medical staff. Dr. Reuter serves as the sole medical doctor, managing a number of rural primary health clinics — each staffed with just one nurse — that are, nevertheless, successfully treating patients with ART in the Eastern Cape.

Voluntary counselling and testing

A heated debate at the conference concerned the question of whether or not to move towards a system of routine HIV testing in which anyone visiting a clinic would be routinely tested for HIV — unless they specifically asked not to be (opting out). Whilst not taking sides, Dr. Venter said "as a clinician I want to get people [early in infection] and not only when they are sick. As a selfish clinician I want the benefits to extend to the healthy to the unworried well. At the very least, there should be more 'active case finding' with VCT offered more aggressively to those diagnosed with TB or sexually transmitted diseases."

Poor accrual of children

"The paediatric numbers are a disaster in some of the provinces. Clinicians are terrified by children — and they are more complicated than adults to treat.

Lab work

The scale-up of the ART-related (CD4 and viral load) laboratory services in South Africa has been very successful in most of the country. However, there are some areas where turn-around times are still too long. But the biggest lab-related challenges are limited access to other types of diagnostic tests — and the fact that CD4 and viral load test results are not being acted upon in a timely fashion (as in the Free State example).

Stock outs

"We've had shortages of drugs in several provinces and that is a disaster," said Dr. Venter. "You can't scream at patients and yell and moan about adherence when in fact, you can't get your act together to buy the drug in time."

Overcoming the obstacles

Dr. Venter provided a number of examples where scale up has occurred more rapidly. He credits much of the success of several projects to Dr. Pierre Barker and the Institute for Healthcare Improvement (IHI), which is working to improve the efficiency and quality of care provided by ART programme in five provinces. "His model is partly the reason for the dramatic upscaling in [these sites]," said Dr. Venter. "Pierre uses data on-site to improve service delivery, and empowers local managers to implement progressive changes in the clinic - small ones that slowly improve the system."

Figure 4

Set a target

Dr. Venter and his colleagues at Johannesburg Hospital worked out that they needed to get about 10,000 people [8-12,000 within the hospital's catchment area] on treatment. "At the beginning of February," said Dr. Venter, "we only had about 2000 people on treatment and we were only putting approximately 80 patients per month on treatment. We worked out that we needed to get 400 on treatment each month [to reach our target in a reasonable time]. Just having that data in front of us we've gone from 80 to about 170, 180 in just a few of months."

Systems management (improving clinic efficiency to free up capacity)

Dr. Venter said that the Harriet Shezi Children's Clinic did exactly the same thing, by working out how many children they needed to get on treatment per month to deal with the paediatric population at Chris Hani Baragwanath Hospital. Then, working with IHI, the clinic team assessed how it was delivering care – systems, workflows, etc – and how they would improve on it. By improving efficiency within the clinic itself (more efficient patient streaming, more effective consultations), the clinic has more than doubled its capacity to start new patients on therapy.

Active case finding

The freed up capacity at the paediatric clinic has allowed the staff to start actively looking for patients to be referred into the service from the inpatient ward. "Once they set themselves this target they went out trying to actively accrue that number of patients from within the Baragwanath system. And now they are steadily getting towards where they need to be."

Accountable project leaders

Dr. Venter says that the Northwestern Province is another relatively recent success, which he attributes to "very driven and accountable project leaders, who are set targets, and given significant power to implement these," according to Venter. "Also, there is very little of the 'can't do anything till everything is perfect' attitude you get in other provinces. Northwestern Province says 'get on with it.' They said 'we are going to do the very best we can with the resources we are given.' But despite having virtually no

resources... they probably have the best ratio of patients on ARV therapy to the patients in need of therapy."

For example, Taung Hospital in rural Northwestern Province has one of the fastest growing ART sites in the country. The hospital has six associated clinics that feed HIV-positive patients into the ART site. Within six months of opening, the site put 12% of the local patients in need of therapy on treatment – at that rate, within 18 months the site should reach about half the patients in need of treatment. Dr. Venter credits "the people driving the programme, implementing it in the [provincial] department of health. The commitment of people like that, and the passion behind it is what makes for a good programme."

Specialty clinics

Another challenge for the rollout in South Africa has been getting pregnant women who need ART for their own health into "rollout" sites before childbirth. Dr. Vivian Black and colleagues at the Reproductive Health Research Unit (RHRU) of the University of Witwatersrand have taken a completely different approach by simply setting up a pilot ART clinic within the obstetrics department of an antenatal clinic. So far, this project has placed 184 women onto treatment. "The pregnancy clinic is fascinating," said Dr. Venter. "Site an ARV clinic in an easy-to-access group, and initiate them!"

Down referral – chronic care at the primary healthcare level

Ultimately, Dr. Venter said, South Africa must move away from hospital run programmes and start treating HIV like any other chronic condition – in primary healthcare clinics (such as those run by Dr. Ndjeka and Dr. Reuter).

The INI-associated projects have begun this process by down-referring patients who are stable on ART to local primary healthcare clinics – in order to keep patient numbers manageable. For example, the Harriet Shezi Children's Clinic has begun to involve two primary health care clinics to provide long term nurse-based care and follow-up for the children on antiretrovirals – much closer to home. Down referral is also necessary if the Shezi clinic wants to keep putting more children on treatment. Otherwise, management of the increasing numbers of patients on ART would quickly saturate all the clinic's recently "freed up" capacity.

But this is only a first step. "We have to turn this condition into a primary health care condition," said Dr. Venter. "We have to get to the stage where people are *starting* antiretrovirals at the primary health care level. This is one of the big challenges in the next two or three years."

Conclusion

"It is too early to call this programme a success or failure but the clock is ticking and we're counting in lives," said Dr. Venter in conclusion. "We have to rededicate ourselves to again and again to work twice as hard and twice as smart to make the programme work – it is an opportunity and a responsibility."

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Online resources:

Many of the plenary presentations and the rapporteur sessions from the 2nd South African AIDS Conference are now viewable online at <http://www.sa-aidsconference.com/>

The website for the Institute for Healthcare Improvement has some good materials on its work in South Africa. In particular, see Dr. Pierre Barker's "blog" and the IHI Start Up Strategy in South Africa: <http://www.ihl.org/IHI/Topics/DevelopingCountries/Africa/>

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A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

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