



PERSONAL VIEW

Launching the ARV roll-out debate into the public arena

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We note with great enthusiasm the recent cabinet decision on the roll-out of antiretrovirals (ARVs) in South Africa.¹ According to information from the Treatment Action Campaign (TAC) on the cabinet document, 'Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector' presented to MINMEC on 9 May 2003,^{2,3} we note, among other items, that the document may underestimate the role of ARVs in preventing HIV infection. We would like to present a case in favour of ARVs as a strategy in the fight against this epidemic.

With reference to the section headed 'Benefits of ARV treatment', there appears to be an underestimate of the role of antiretrovirals in preventing new infections. The section states that there is '... no compelling evidence that ARVs would reduce numbers of new infections ...'. Prevention of new infections may in fact be decreased in a number of ways: (i) by decreasing the viral load in the mother, transmission to the infant is significantly decreased;⁴ (ii) decreasing the viral load in patients reduces horizontal transmission,⁵ and may well have a beneficial epidemic-level effect; (iii) modelling exercises based on examples from developed and developing countries have shown that antiretrovirals, even in the light of resistance, significantly decrease the transmission of HIV-1 in high, intermediate and low ARV usage scenarios.⁶ On the basis of this model and other adapted models,⁷ taking into account the effect of resistance developing on ARVs,⁸ it is estimated that 10 - 30% of new infections in South Africa could be averted if 50% of patients who require antiretrovirals were receiving them; (iv) improved AIDS care may indirectly enhance prevention efforts through increased uptake of voluntarily testing and counselling, the foundation and entry point to all care interventions;⁹ (v) improved care leads to de-stigmatisation of

the disease,^{10,11} which improves compliance and access to health care.⁹

South African prices for both first-line regimens are significantly more expensive than the best world prices. The costs could be dramatically reduced by facilitating domestic production or importation of generics, reflected in the imminent production of generic ARVs by South African drug companies,¹² and affords the opportunity to double or treble the number of patients that could benefit from ARVs.

While we agree that it is imperative that any programme should ultimately reach those in 'desperate need' this should not delay implementation in regions with the necessary infrastructure in place. It should not be assumed that this will only be in urban areas. Several institutions in rural KwaZulu-Natal could implement ARVs immediately. The constitution guarantees all South Africans the right to access health care, and we understand the government's concerns regarding initially providing ARVs to specific groups such as teachers or health staff. However, this would have two advantages. It would help maintain essential public services. It would also enable managers to evaluate and rectify possible problems in a sub-group of the population that is better educated and better nourished before rolling out to the rest of the country, and this sub-group of patients could act as advocates for compliance issues associated with long-term HAART therapy. As many privately employed South Africans already have access to ARVs a disparity in health care already exists.

Following this announcement, we urge the government to implement a widespread public ARV programme without further delay, starting in areas of adequate resource. A novel approach to reach areas of most need could be to encourage provinces with expertise, such as KwaZulu-Natal, Gauteng, Western Cape and Free State, to 'adopt' neighbouring provinces to assist with setting up pilot sites and rapidly scaling up, thus sharing expertise and resources such as training and technical support.

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