



## Antiretroviral treatment roll-out policy is in place — now for the implementation challenges

To the country's collective sigh of relief, the South African government announced on 8 August 2003 that it would provide anti-AIDS drugs free of charge in the public sector, thereby putting an end to years of controversy marked by court battles and other forms of confrontation with the Treatment Action Campaign, the South African Medical Association and other civil society formations.

And on 20 November 2003, the Cabinet approved the 'Operational Plan for the Comprehensive Treatment and Care for HIV and AIDS' (the Plan) prepared by the Department of Health. In this well-considered plan, the provision of antiretroviral (ARV) treatment in the public sector is but one of a number of strategies to deal with the HIV and AIDS epidemic. The Plan proposes designated HIV and AIDS service points across the country, and envisages that, within a year, there will be at least one service point in every health district (there are 56 health districts altogether) and within 5 years, one in every municipality. 'Some areas will be able to start sooner than others, and the Department of Health will keep the public informed of the progress of the rollout' according to Minister Manto Tshabalala-Msimang.

The government is quite rightly determined that the provision of ARV treatment does not detract from the broader campaign against the HIV/AIDS pandemic. Other elements of the plan therefore include 'stepping up the prevention campaign so that the 40 million South Africans not infected stay that way; improved efforts in treating opportunistic infections for those who are infected but have not reached the stage at which they require ARVs, and intensified support for families affected by HIV and AIDS'. A potentially controversial proposal is to 'expand programmes aimed at boosting the immune system and slowing down the effects of HIV infection, including the option of traditional health treatments for those who use these services'.

There is currently an unprecedented local and global focus on the funding of ARV treatment to AIDS victims on the African continent. The World Health Organisation's '3 by 5 Initiative' seeks to get ARVs to 3 million AIDS sufferers in the developing world by 2005, while the Clinton Foundation HIV/AIDS Initiative intends to provide treatment to as many as 2 million people in Rwanda, South Africa, Mozambique, Tanzania and the Caribbean by the year 2008. The Canadian government and the US Bush administration have both pledged significant resources in this regard. Here at home, SAMA has launched its own treatment programme, called the Tshepang Campaign, and the government plans ultimately to devote 11.5% of current public sector health spending — an equivalent of US\$687 — to the programme by 2007.

### One of a kind

The envisaged South African ARV treatment programme will be the largest in the world, without precedent in its sheer size and scope. In no other country has a universal AIDS treatment programme involving the sort of numbers we are talking about

in the Plan been attempted. In Zambia, only 7 000 people are currently receiving drug treatment, with plans to increase this number to 10 000. Malawi recently unveiled plans to provide treatment for up to 50 000 people, using a grant from the Global Fund.

This column has previously underscored the mammoth logistical and human capacity challenges confronting the implementation of an ARV treatment programme of the magnitude envisaged for South Africa. These include the prerequisite to train appropriate staff — counsellors, social workers, nurses and doctors; the need to ensure the reliable supply and the secure local storage of specialised drugs; the need for access to essential laboratory monitoring; the challenge of ensuring the reliable tracking of possibly millions of patients under treatment; the threat of non-compliance and treatment interruption leading to widespread drug resistance; and so forth.

A news item on the Health Systems Trust website dated 19 December 2003 observed that 'despite the government's decision to roll out the provision of ARVs, a lack of planning has meant temporary [drug] shortages — and could presage future crises if problems are not dealt with. An interruption in ARV treatment could have serious health consequences for people on a programme of treatment. Inconsistent supply of ARVs could kill [patients] sooner than the disease itself.'

The Plan has anticipated these potential difficulties. The final draft drawn up by the department's ARV task team has set aside a significant portion of funds for the training of thousands of nurses, doctors, laboratory technicians, counsellors and other health workers.

The place of nutrition in the management of people living with AIDS has been the subject of some controversy in South Africa, where some voices were understood to be advocating it as the sole remedy. There is general agreement, however, that good nutrition has an important role to play in the prevention and management of HIV and AIDS, as with any other serious illness. In this regard, Lucy Steinitz of Namibia's Catholic AIDS Action has expressed concern about the region's drought and food shortages affecting more than 6.5 million people that, she says, will make the task of managing AIDS even more difficult.

The controversies over the government's position on the causation of AIDS have served to obscure South Africa's gains of the last few years in the fight against HIV, including the successful campaign for affordable ARV prices in the region.

The implementation challenges notwithstanding, and given the worldwide scorn we have had to endure over the last few years, the Plan represents a bold and important initiative whose time has come.

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