ARV ROLL-OUT — THE QUICK AND THE DEAD

For the second time in as many years the Treatment Action Campaign (TAC) has speeded up the government's provision of AIDS drugs, this time by carefully preparing and then merely threatening, court action.

A pregnant protestor during the TAC protest march in Cape Town on 14 February last year.

Their confidence buoyed by three court victories that ensured government provided nevirapine to prevent mother-to-child HIV transmission 2 years ago, the TAC has again got ARV drugs flowing months quicker than the government claimed possible.

National health chiefs told parliament in late February that the ARV medicines on tender were expected to be issued in the last week of May, with delivery to the accredited treatment sites 2 - 3 weeks later.

Provinces depend on national government for the procurement and supply of medicines. In a 'letter of demand' served on the Minister of Health and her nine provincial counterparts, the TAC argued there was 'no rational, reasonable or lawful basis' for the State's failure to urgently procure ARV drugs on an interim basis, pending the finalisation of the tender process.

It also highlighted precisely which laws the government could use to do so.

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Provinces that had not struck up private funding partnerships were hamstrung by a law forcing them to use current conditional grant allocations to buy only medicines procured in terms of the national tender process.

TAC lawyers (specifically the AIDS Law Project at Wits University) gave the government until end of March to speed up the drugs flow to the more than 40 sites across the country capable of safely and effectively treating qualifying patients.

A MinMEC (Health Minister and her provincial counterparts) meeting in late March then promptly decided to use an (alternative) national comparative price quotation system to buy ARV drugs until the tender procedure was finalised.

This enabled provinces to use their conditional grants to buy the drugs from central government far sooner than the tender process would have otherwise allowed.

Dr Manto Tshabalala-Msimang confidently asserted in early March that the national tender mechanism would 'have to' be followed. Her spokesman, Sibani Mngadi, told the *SAMJ*, 'We now have 27 HIV and AIDS service sites accredited and this will enable provinces to properly quantify their drug orders and let us get decent estimates of what's required initially'.

Speaking on 1 April, he said the drug supplier quotes 'should be in within 3 or 4 days and we can then identify the cheapest, safest supplier. After that we'll be able to tell you exactly when the drugs should reach the central provincial depots'.

There are an estimated 110 sites that Health Department inspectors are visiting to ensure capacity and quality control, of which they have so far accredited 27.

The aim is to have a central ARV drug depot in every one of the country's 53 health districts.

Mngadi said a 5-year target was to have accessible ARV services at municipal level throughout the country. Mrs Felicia Serenata, National Project Manager for HIV/AIDS, told the *SAMJ* that the 'three quotes system' was also being used to fast-track health care worker training. This was because a 'technical dispute' around the proper advertising of the training tender had caused delays.

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The dispute was only due to be adjudicated in mid-April, so her staff had provisionally gone ahead and secured quotes.

'We're primarily using the Foundation for Professional Development, but there's also your ATTICs and other service providers doing training,' she said.

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Mrs Rose Mdlalose, Director for Human Resource Development in the national health department, said the training manual and guidelines had been approved.

Her department would support the five provinces that had the most limited resources, starting with Mpumalanga. She listed the others as North West, the Eastern Cape, Northern Cape and Limpopo.

Serenata said electronic versions of the treatment guidelines were being e-mailed to those provinces ready to use them because 'hard copies' were still being printed.

A national department of health media update at the end of March said the ARV site accreditation process was 'exposing major gaps' in the national health system.

Flaws included a poor patient information system, provincial health information systems that did not talk to one another, the lack of a comprehensive laboratory service network at point of service, poor recruitment and retention of medical, nursing and pharmacy staff and the lack of a baseline survey 'to establish our starting point'.

The department said it saw the job of accredited facilities as HIV testing, CD4 cell and viral load counts, providing nutritional and micronutrient supplements and providing traditional medicines and improving step-down referral facilities.

Treatment literacy was a priority to ensure compliance for those patients 'who qualify for and prefer antiretroviral therapy'.

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Cabinet adopted a comprehensive HIV/AIDS treatment plan on 19 November last year that included a target to roll out antiretroviral therapy to 53 000 people nation-wide by 31 March this year. Instead, some 2 500 people were estimated to be on ARVs by that date, most of them in the Western Cape and relying on private, provincially facilitated, drug funding.

Chris Bateman

IN BRIEF

Is combination therapy more beneficial after AMI?

In patients referred for post-infarction percutaneous coronary intervention (PCI), pharmacological therapy is usually applied in the interval between the onset of the acute myocardial infarction (AMI) admission to the treatment facility and performance of the treatment. The optimal pharmacological therapy for this period is not known. A trial was recently conducted to assess whether early administration of reteplase (a fibrinolytic agent) and abciximab (an anti-platelet agent) produces better results with PCI. The trial involved 253 patients who were randomised either to the combination therapy or to abciximab alone prior to PCI. The researchers concluded that the combination therapy does not lead to a reduction of infarct size compared with abciximab alone, and clinical outcome was not improved. The latter finding, they say, should be interpreted with caution, and deserves confirmation from the larger ongoing FINESSE trial.

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