NURSE LED/PHC INITIATION OF ART

By
Dr V G Fredlund MB BS (LOND)
Mseleni
Why do we need PHC ARVs

Because hospital only delivery creates something worse than a bottle neck in service! If creates a funnel!

• Let me illustrate.
What happens to those who do not get on therapy

• is not delay
• it is
• DEATH
• between 2004 and 2009 approx 4.5% of the population failed to get the treatment they needed and DIED (450,000 people!) in KZN
KZN roll out to Aug 2009

- on therapy
- in need of therapy
- lives saved
- lives lost
- Series 5

weeks

KwaZulu-Natal Department of Health
• As a province we have not achieved universal access yet. Each week 2500 more need therapy and only 1200 get it!
• More than 450,000 have died since rollout start and in the next 5 years a further 300,000+ will die if we continue at the present rate.
• 120,000 still are in the pool of those who need treatment but are not getting it.
• To achieve our goal the rate at which we put people on treatment should exceed the rate at which new patients enter the pool of those needing it!
So what blocks the funnel?

- Political
- Conceptual
- Patient derived
- Service derived
Political blockage

• Have we the will to run a programmatic roll out to meet the extent of the need?
• Will sufficient public finance be provided for everyone? Or what proportion?
• Will treatment protocols be politically determined or clinically appropriate?
Conceptual blockage

- Can we even imagine treating everyone??

**Only the best for the patient in front of me is good enough** **VERSUS**

**Only the best for the whole community is good enough**

KwaZulu-Natal Department of Health
whilst we have served some individuals well

We have failed
the whole community
Patient derived blockage

- Presenting for testing only once sick, if at all.
- Refusing treatment until it is too late.
- Unable to access distant treatment centres.

Remedy - educate
Remedy - relocate

KwaZulu-Natal Department of Health
Service derived blockages

- Too few prescribers –
- All doctors get on board

This is an emergency

- Task shift to counsellors and PHC nurses doing follow up.
Too little space in special clinics

• Desegregate HIV
• Utilize existing clinical areas and all health facilities
• Extend hours of service if necessary
• Decrease frequency of routine follow up visits
Patient flow

- Too many recalls for results – use point of care testing where possible
- Too much back tracking through clinical care pathway. Stream line by consulting all care providers. (eg ANC clinic process)
Drug supply

• This has not been a blockage in our experience apart from right at the start when we had a problem with Efavirenz supply.
• However need to inform manufacturer in good time of intentions and projections
• Adequate storage space for volume expected
Complexity of care

• Restricting ART to advanced AIDS and low CD4 makes it more complex. Greater need to look hard for hidden OIs. Less satisfactory protection from further OIs.

• We could remove all the less complex to an early initiation programme and have only the advanced cases reviewed by doctors?
Way Forward

1. Have a vision of 100% coverage. Don’t plan to underserve. Plan to meet population need with level of service which can be afforded.
2. Simplify treatment as much as possible. Start earlier, use less toxic drugs as become available and affordable
3. Increase workers in line with the target objectives
4. Multiply the sites of delivery by utilizing all health points
5. Have service delivery teams regularly review their processes to iron out local issues – operational procedures etc.
6. Educate the whole population as to risk/benefit of regular testing and treatment.
Now we have the opportunity!

• Umesh said ‘we have the tools at our disposal to prevent HIV spread’
• Are we going to waste it?
AIDS threatens the health of all and even the healthcare of those who do not have it as it draws resources and attention to itself.
July 2004

- We got permission to start at all our clinics
- 8 clinics plus hospital
- Counsellors at each
- Doctor, pharmacist, social worker, dietician visiting
- Improved lab services with daily collection
- Integrated service
advantages

• Attention turned towards clinics
• All clinicians involved – all consultations consider HIV as part of the condition
• Ease of access and reduced bottlenecks
• Increased community awareness
• Family centered
• Status of clinic enhanced in community
• Aug 2008
• 3884 on ARVs
  – Adults 3561 (female 65%; male 35%)
  – Children 323
• Basically universal access
• 9+% of adults; 0.7% of children
• Now to maintain cover we need to add 20 per week until we reduce the infection rate
• 25,000 (60% of adult pop) had HIV test in last year
• > 95% pregnant mums had HIV test
• > 98% of +ve had PMTCT 32% on HAART
• > 95% of +ve had CD4 result in notes when arriving in labour ward
• AZT programme now available all clinics
now

- About 2500 died as we struggled to reach them over the first 4 years
- Instead of 20 AIDS deaths a week, 2 or 3
- Approx 4000 people are alive who would have been dead by now! (9% of our adult population)
- 1000 (+/-4% of male pop) Circs done at PHC clinics and hospital – now another day of MO visit to clinic!
- Increased staffing
- Increased professional supervision
- Developing larger structures
- Better laboratory services
- Better positioned for other public health concerns
- Has the attention of fund holders
NIMART should not be another vertical programme drawing nurse attention away from other diseases.
NIMART should be a fully integrated service with all other PHC appropriately delivered with full team support.
NIMART Should not be an excuse for doctor non-involvement in ARVs.
Young doctors now doing comserve were in year 1 of med school at the start of ARV roll out. There is no excuse for them not being fully conversant with the need for and the process of ARV provision!