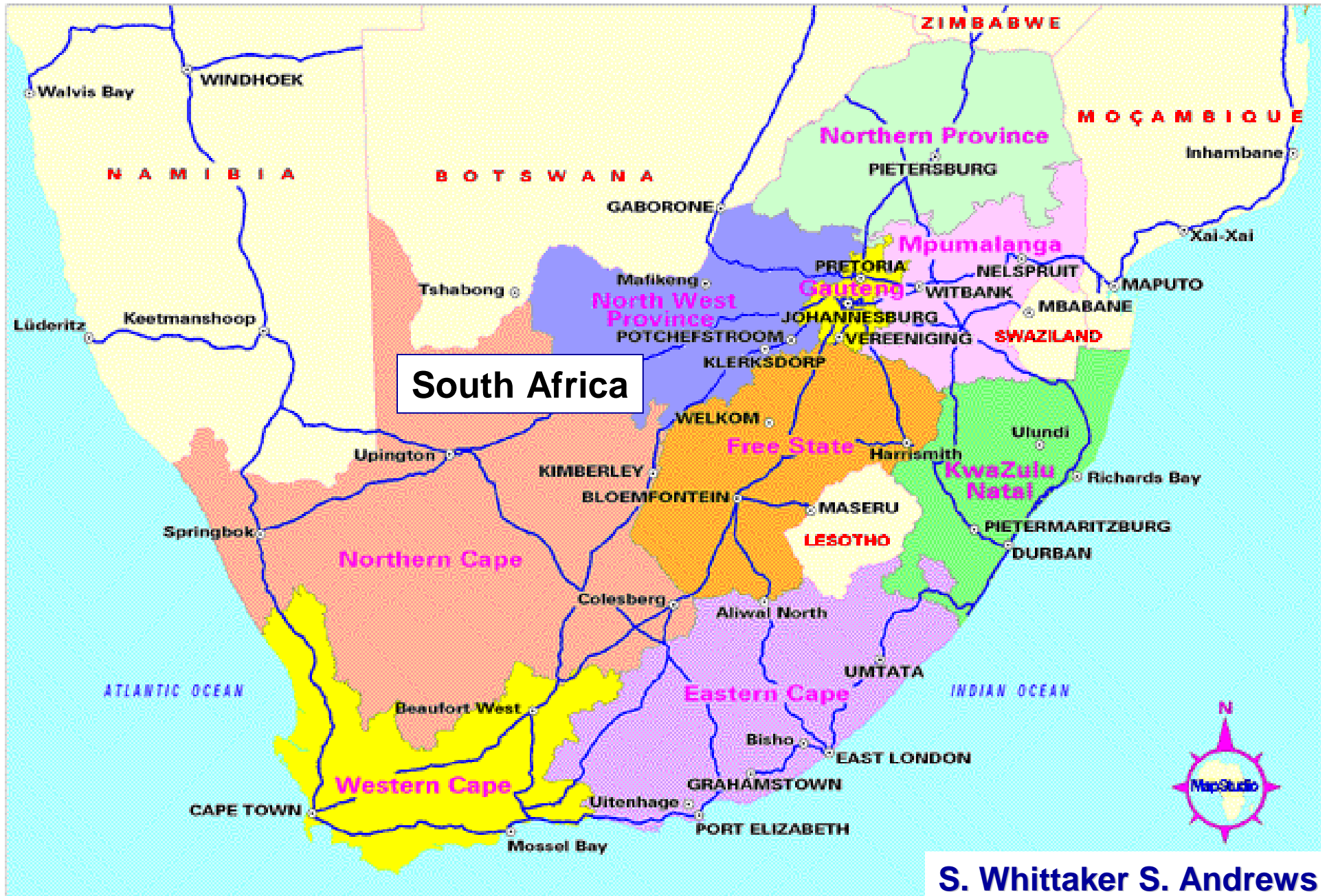


HIV / AIDS in Southern Africa





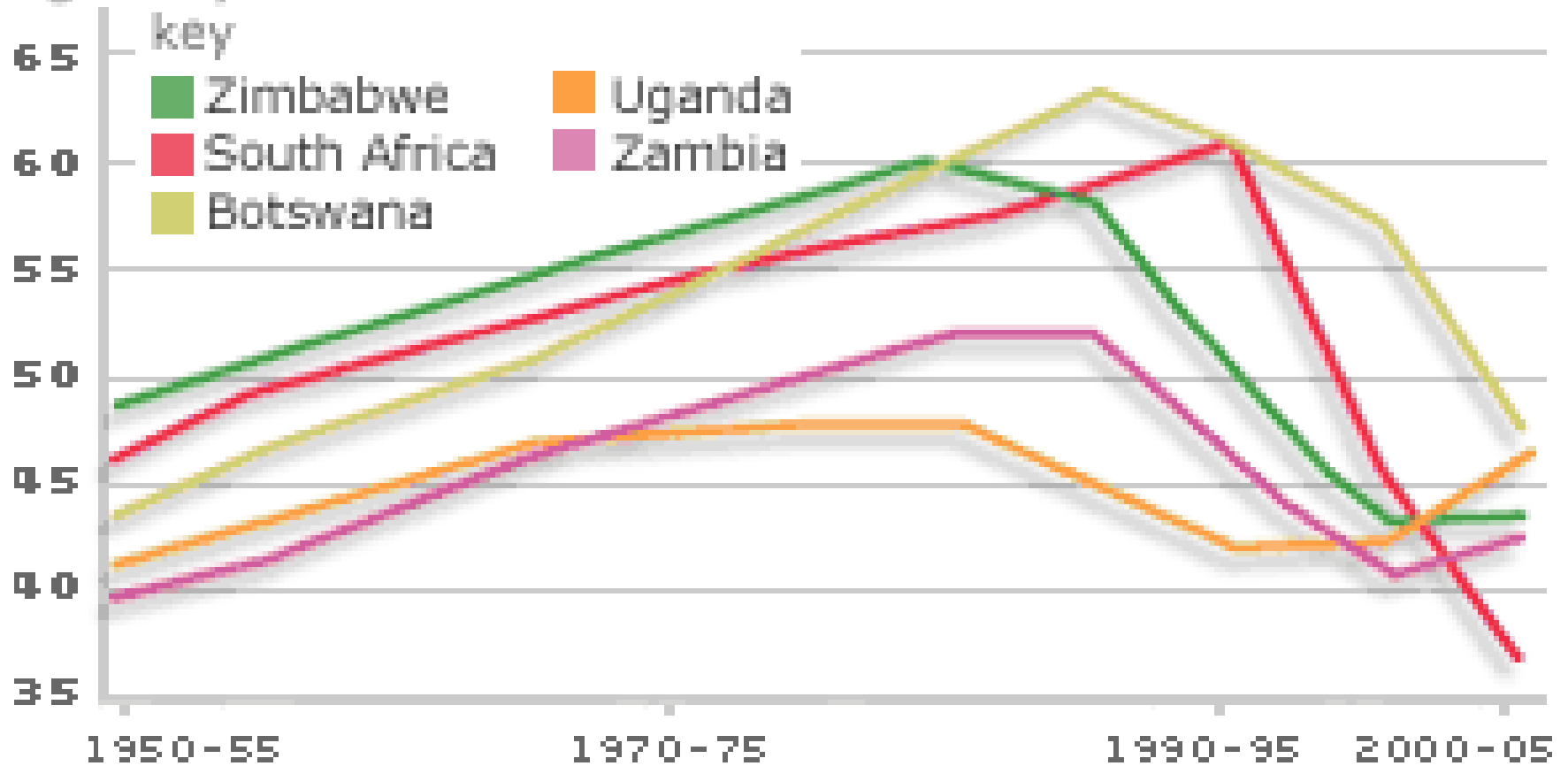
**About 40 million people are estimated to be living with HIV/AIDS
About 85% live in the developing world**



They are now making their presence felt

Aids in Africa, life-expectancy

Age in years



SOURCE : UNITED NATIONS POPULATION DIVISION

Overall HIV+ prevalence by sex in South Africa 2005

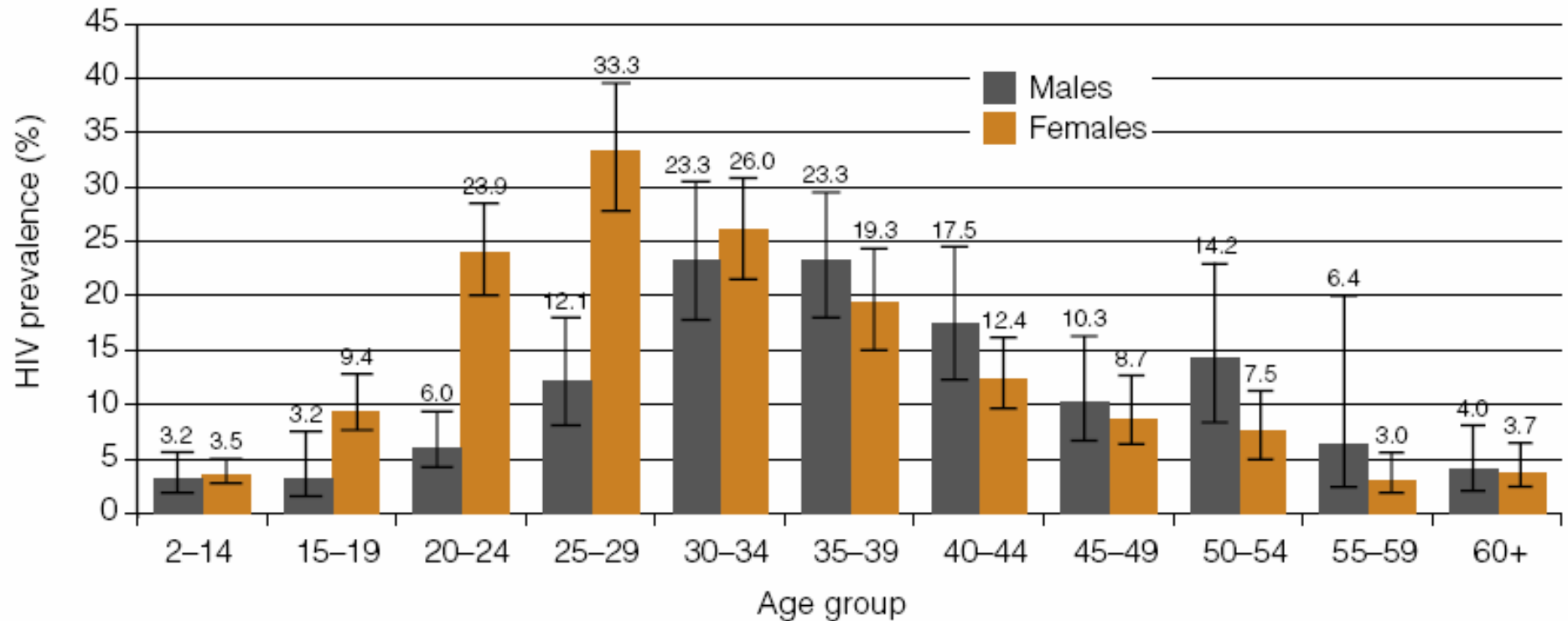
Sex	n	HIV+ %	95% CI
Male	6 342	8.2	7.1–9.6
Female	9 509	13.3	12.1–14.6
Total	15 851	10.8	9.9–11.6

Annual incidence rate 2006 (%)

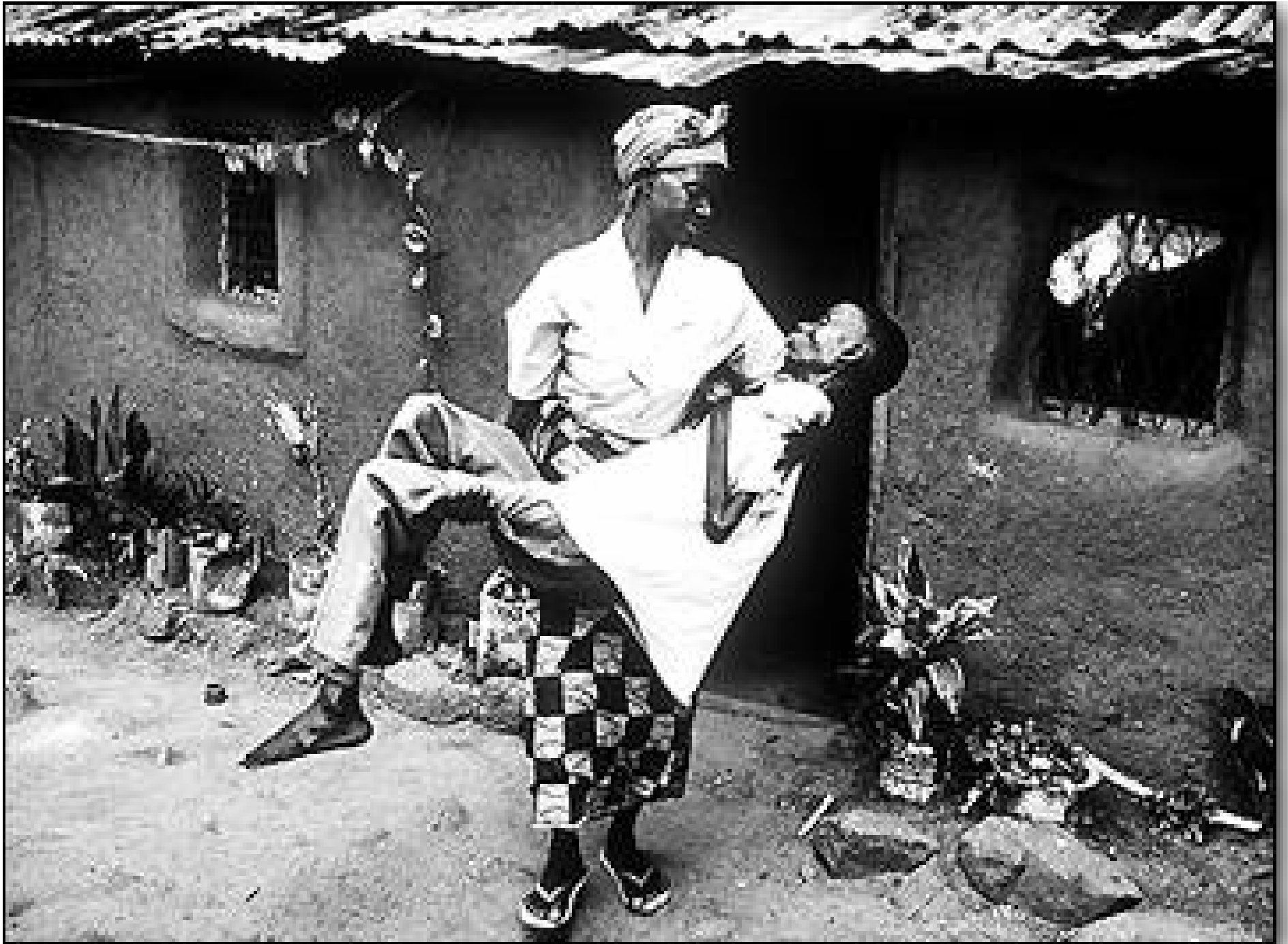
- **Total** 2.7
- **Male** 1.5
- **Female** 3.6

Adults 25-34 yr old 7.1

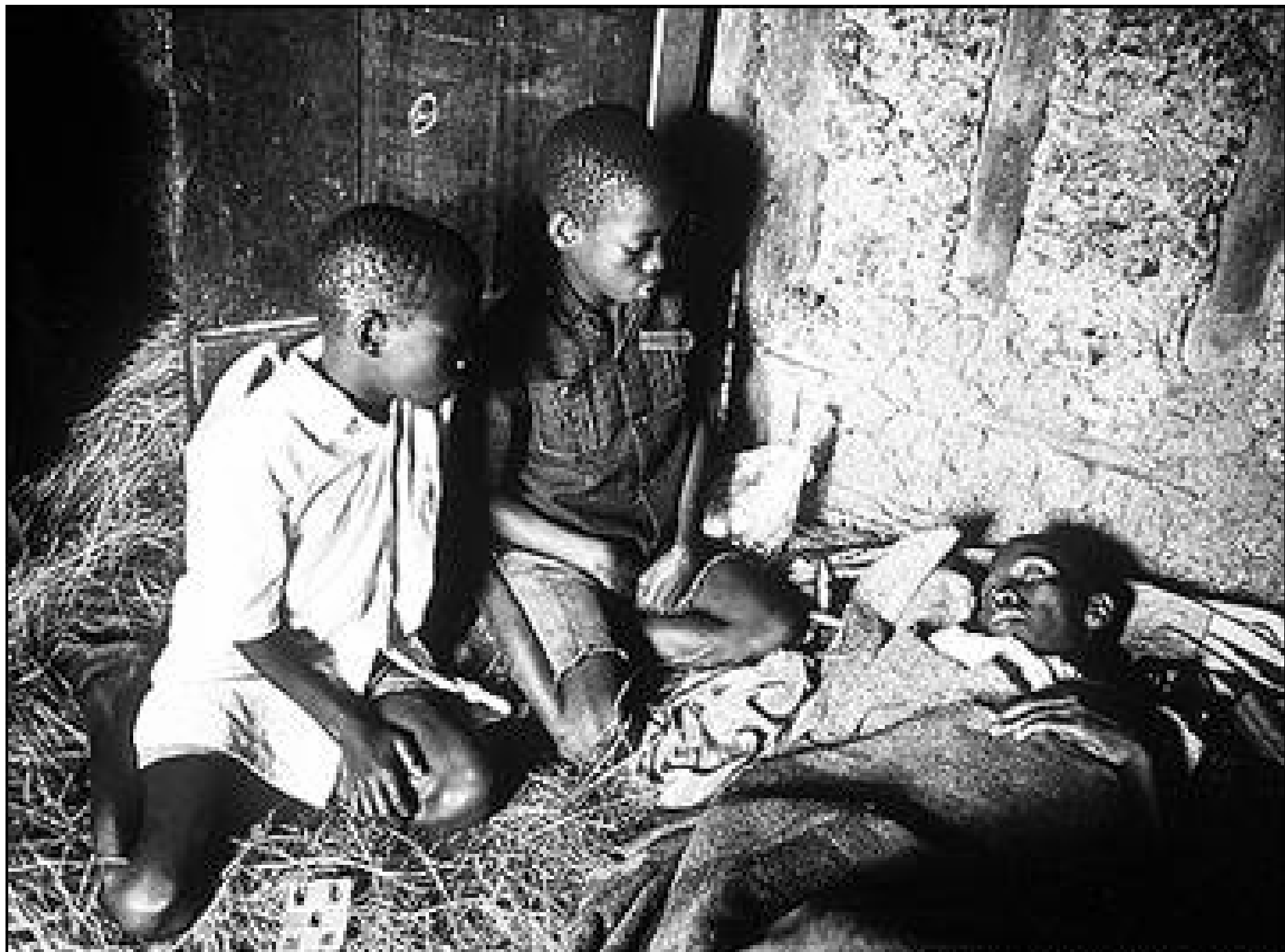
Prevalence by sex and age group, South Africa 2005



Behind the scenes



Gideon Mendel / Network - SABA



Gideon Mendel / Network - SABA

MACRO-ECONOMIC COSTS TO S.A.

- **S.A. ECONOMY** (S.A. BUREAU FOR ECONOMIC RESEARCH)
 - GDP 0.5% SMALLER EVERY YEAR TILL 2015
 - OVERALL ECONOMY 1.5% SMALLER BY 2010
 - OVERALL ECONOMY 5.7% SMALLER BY 2015
- **DEMOGRAPHIC EFFECT**
 - 10 MILLION FEWER PEOPLE BY 2015
 - HIV/AIDS PREDOMINANTLY AFFECTS THE
- **ECONOMICALLY ACTIVE AGE-GROUP**
 - HIV/AIDS CRIPPLES BEFORE IT KILLS
 - PROLIFERATION OF AIDS-ORPHANS

The impact on health care

Study carried out in KZN 2004

Response of hospitals:

- The threshold for admissions of patients has been raised.
- Referrals to community services have increased.

Treatment of non-HIV patients has changed:

- Many patients normally admitted are treated as outpatients.
- Admitted patients are managed out of the acute phase and then discharged and treated as outpatients.

The level of clinical care has declined:

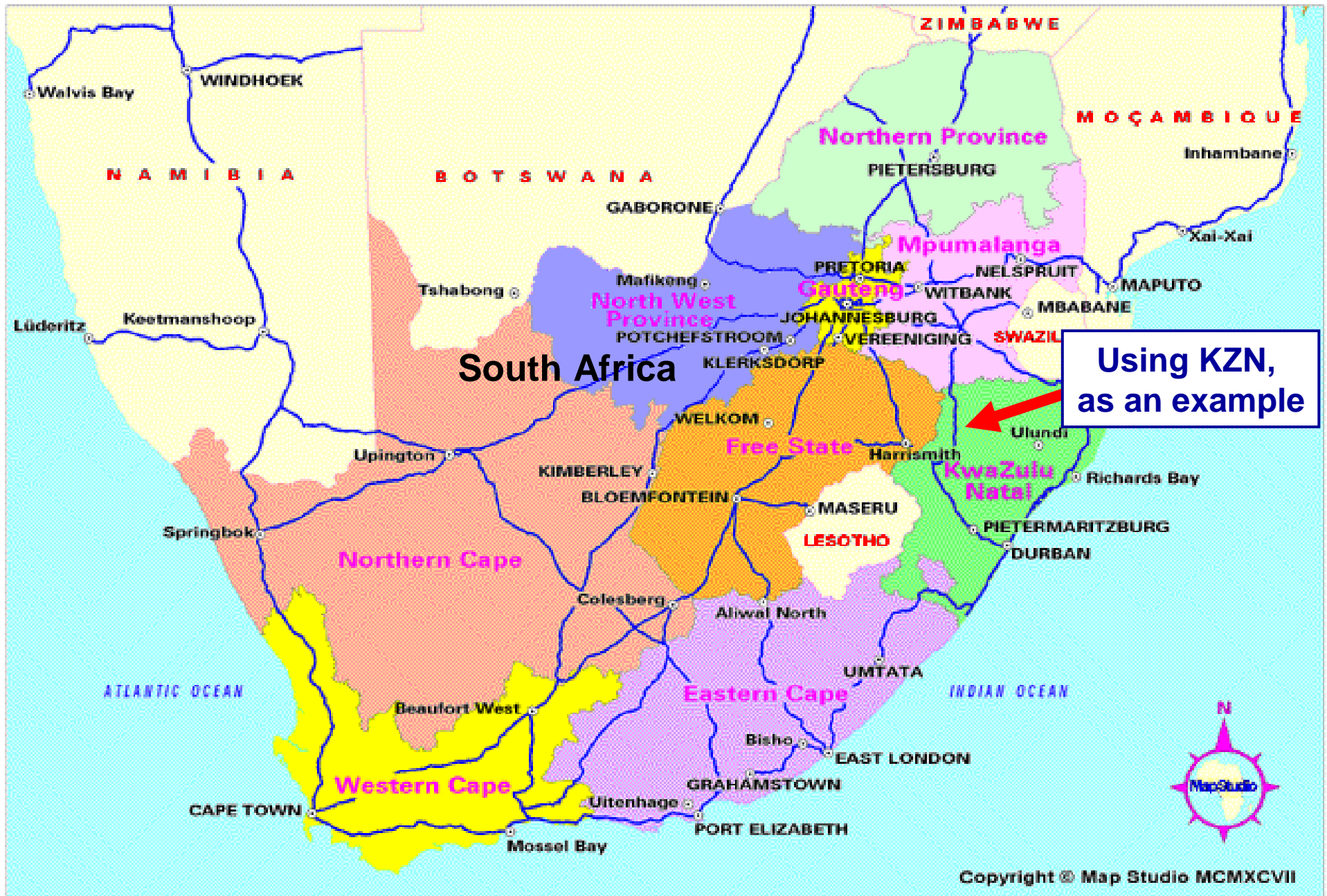
- Less monitoring
- Shorter periods of assessment
- Greater reliance on nurses to assess and treat patients

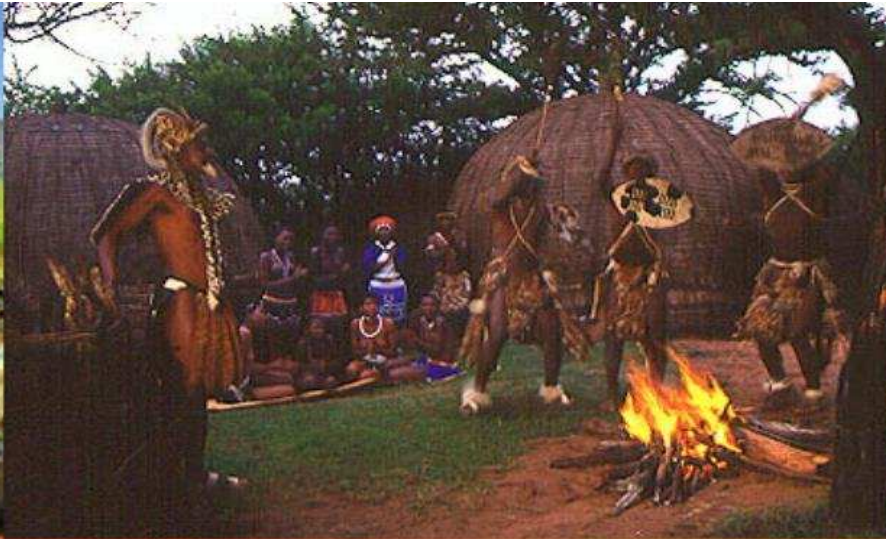
Impact on staff significant:

- Increasing stress on staff who have to cope with heavier patient loads
- Deaths of young people make doctors feel helpless
- Increased risk to themselves
- Many staff are dying of AIDS

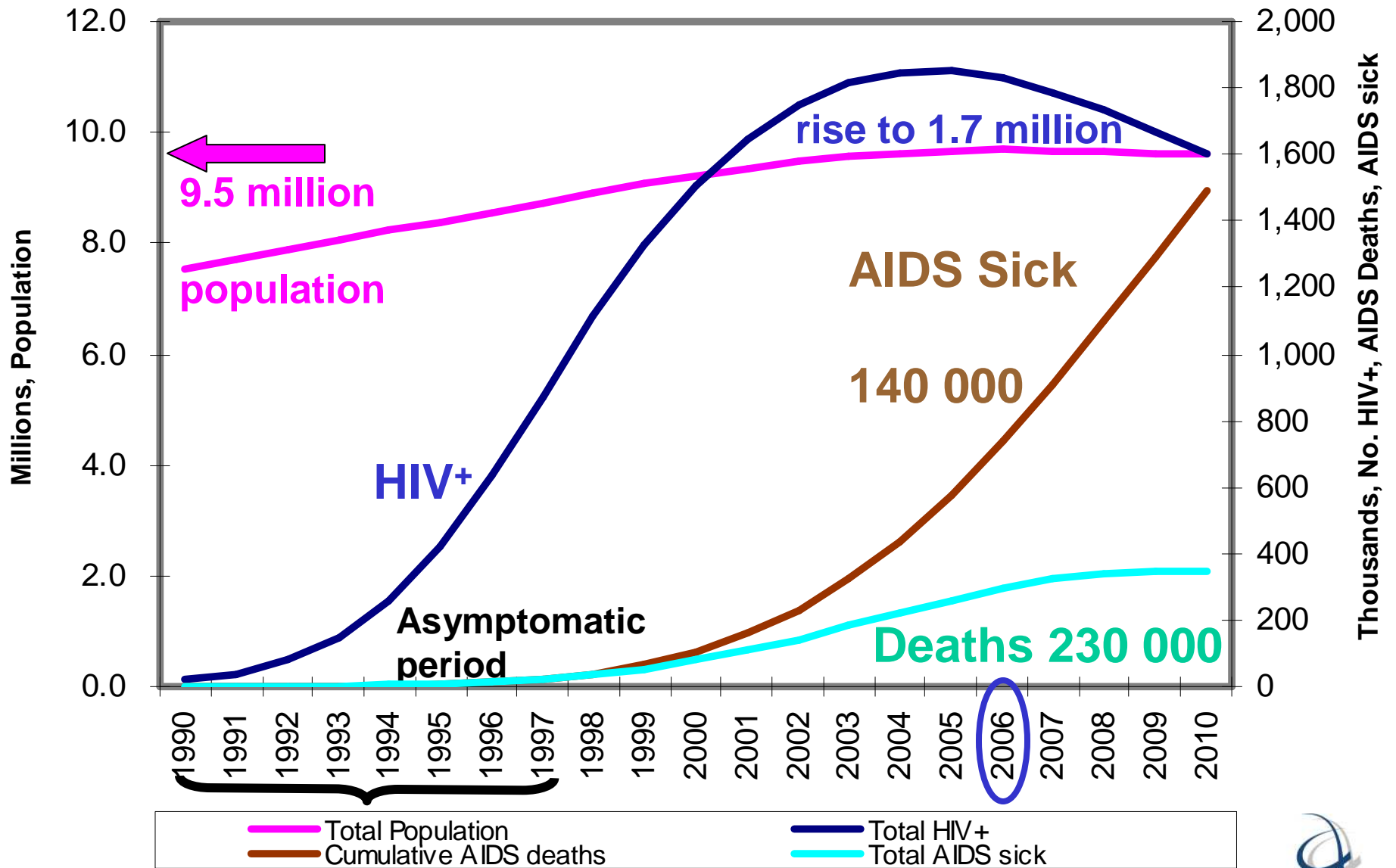


How did it get this bad?





However, a serious epidemic started in this lovely province of South Africa in the early 1990s



Year	Total Population	Total HIV+	Cumulative AIDS deaths	Total AIDS sick
1990	7 514 578	18 614	104	168
1991	7 696 067	40 451	276	410
1992	7 879 173	81 336	677	943
1993	8 052 556	151 171	1 548	2 012
1994	8 223 087	261 854	3 319	4 020
1995	8 384 742	423 140	6 716	7 584
1996	8 529 882	633 695	12 839	13 417
1997	8 714 258	873 713	23 252	22 422
1998	8 890 733	1 112 987	40 352	36 528
1999	9 057 974	1 326 931	66 733	54 885
2000	9 211 922	1 504 196	105 340	79 238
2001	9 348 732	1 643 162	159 216	108 569
2002	9 464 671	1 745 490	231 265	143 222
2003	9 556 833	1 813 217	323 962	181 582
2004	9 623 198	1 848 217	Deaths 438 910	222 153
2005	9 663 375	1 853 006	increase 576 305	261 660
2006 Pop.	9 678 981	1 831 347	734 535	296 928
2007 decline	9 673 613	1 788 587	910 100	324 457
2008	9 652 692	1 731 160	1 097 978	342 129
2009	9 622 429	1 666 034	1 292 322	348 975
2010	9 589 177	1 599 512	1 487 357	345 949



Increase of +/- 40 000 additional AIDS patients/year from 2000

Aids treatment has been delayed in South Africa



And citizens are becoming concerned

Treatment Action Campaign



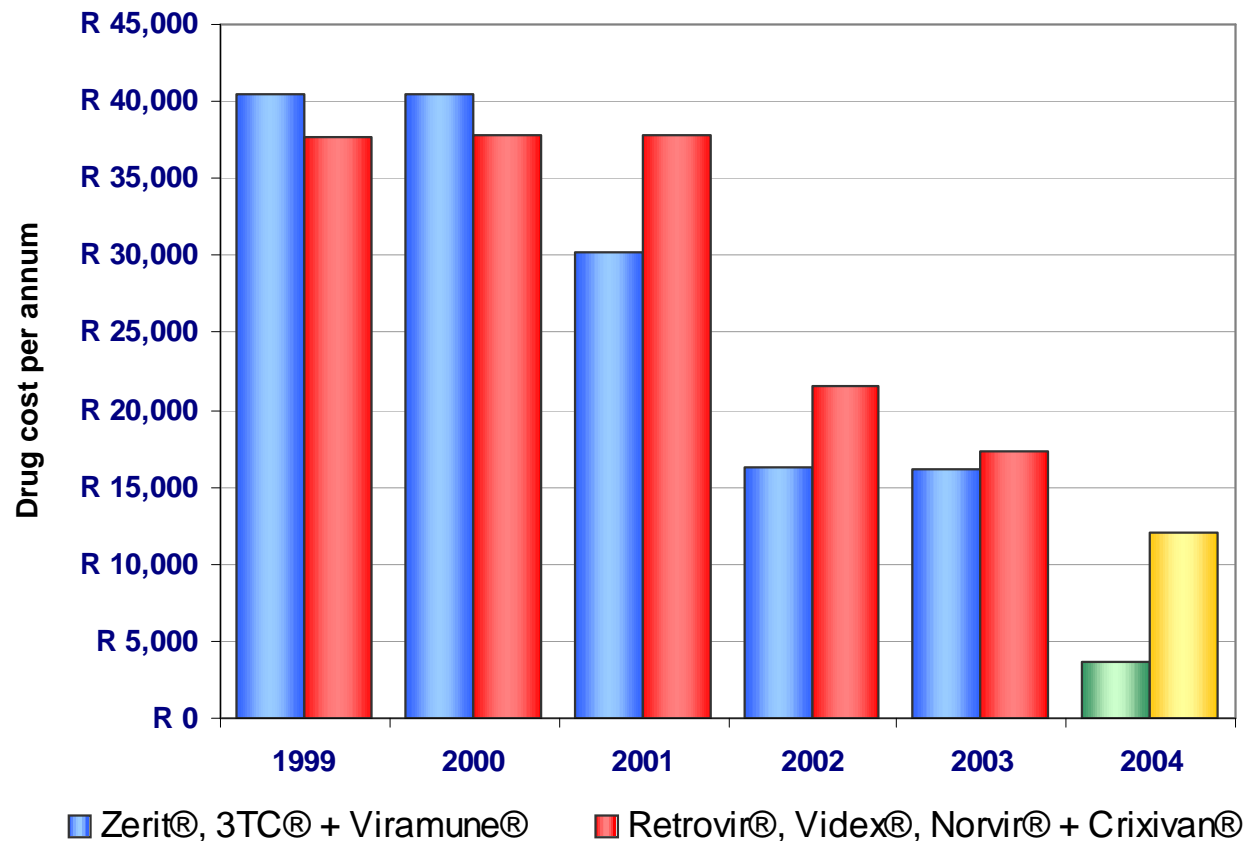


Managing the burden of disease

The ability to help patients suffering from AIDS depends on:

- * Costs of ARVs**
- * Infrastructure deficiencies in the healthcare system**

Annual cost of antiretroviral therapy

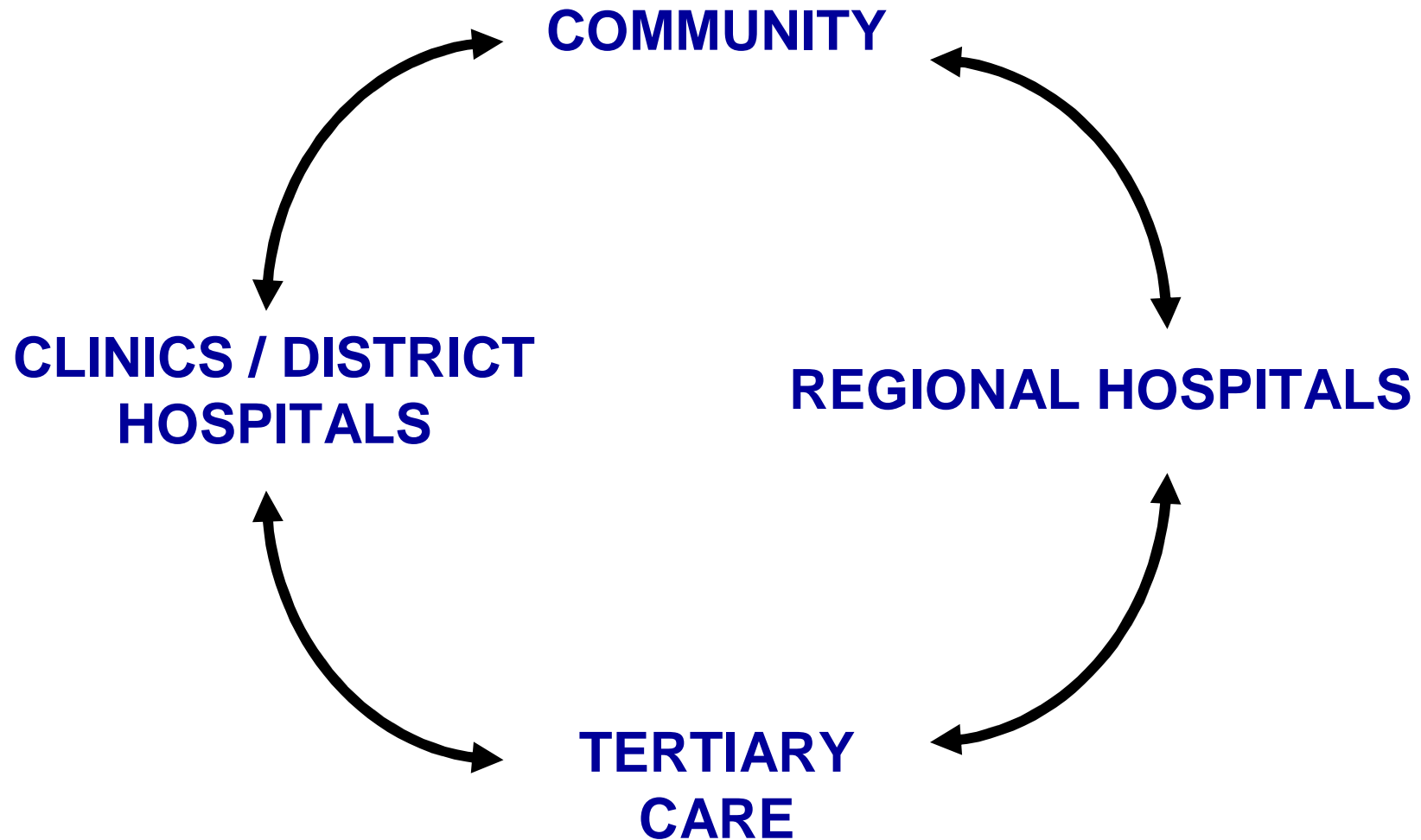


From late 2003, generic ARVs becoming available

Now R270 per month in gov. sector

Infrastructure required to treat this medical condition

Continuum of care is essential



***SCOPE of community STANDARDS
defining HIV / AIDS patient management
according to needs***

**Treatment of Opportunistic
Infections (OIS)**

**Prevention of Mother-to-Child
Transmission (PMTCT)**

**Voluntary Counselling and
Testing (VCT)**

SE ARVs/Adherence

Nutrition

Palliative care

Prophylaxis OIs

Basic OI/ARV training

Condom use, etc

Train the trainer

***SCOPE OF STANDARDS defining in-
patient management according to AIDS
patients' needs***

**ICU management of stage 3 & 4 disease
as required**

**Treatment of Opportunistic Infections
(OIS)**

ARVs 1 and 2

**Prevention of Mother-to-Child
Transmission (PMTCT)**

**Voluntary Counselling and Testing
(VCT)**

SE ARVs/Adherence

Nutrition

Palliative care

Implementation of the HIV / AIDS management standards

HIV / AIDS management standards will serve as a blueprint to assist staff:

to manage their AIDS patients;

to provide guidance on staffing needs, including training;

to specify physical, managerial and administrative requirements to successfully provide such care.

Focus of standards for HIV Care:

1. Management.
2. Risk management.
3. Voluntary counselling and testing.
4. Clinical care.
5. Clinical support.

1 Management

- Management and leadership.
- Human resource management.
- Administrative support.
- Access to care.
- Patient and family rights.
- Management of information.
- Quality management and improvement

2 Risk management

- Health and safety.
- Prevention and control of infection.

3 Voluntary counselling and testing

- Voluntary counselling and testing

4 Clinical care

- Antiretroviral therapy.
- Management of opportunistic infections.
- Patient care.
- Obstetric / maternity care.
- Community – based care.

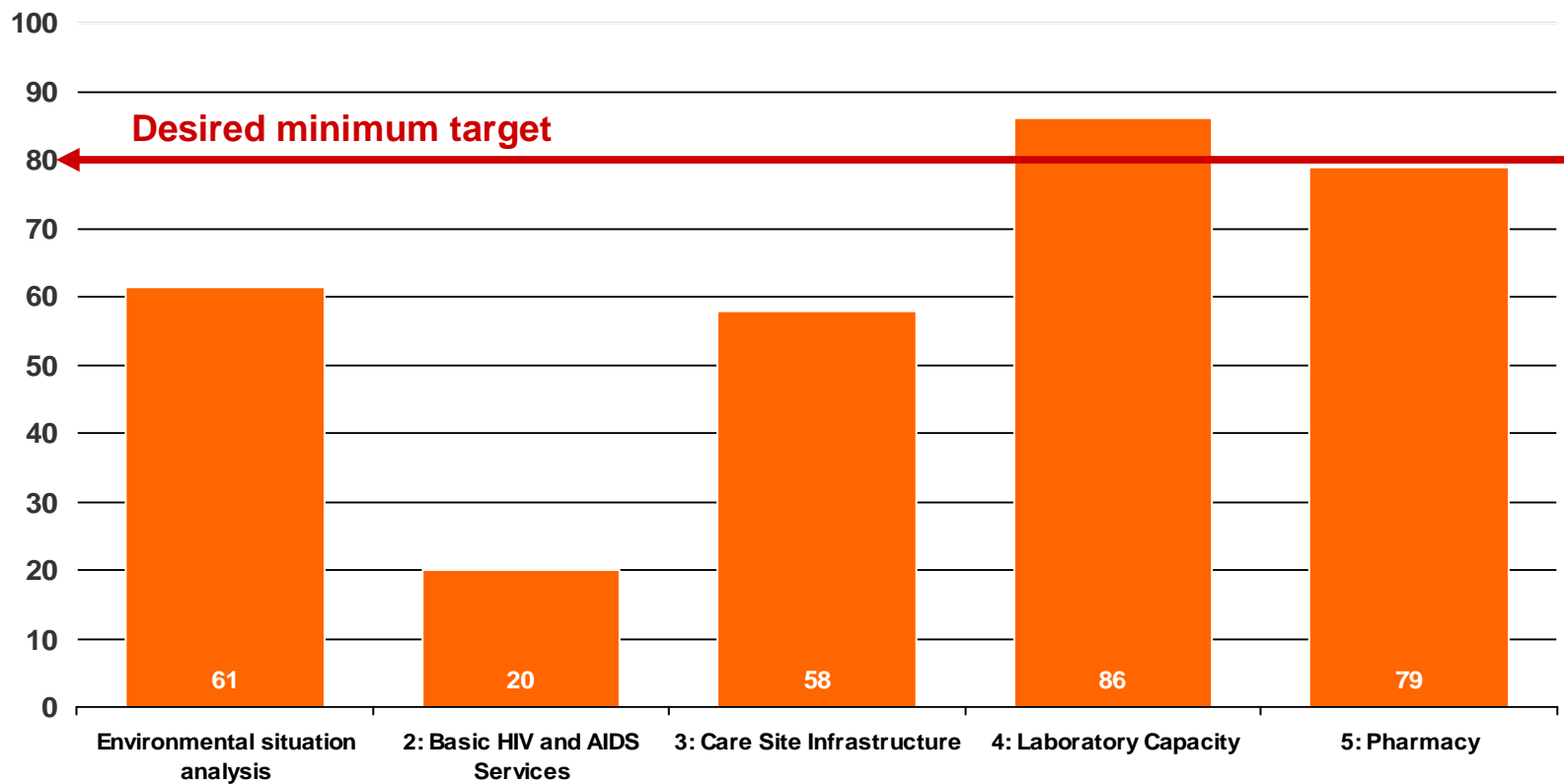


5 Clinical support

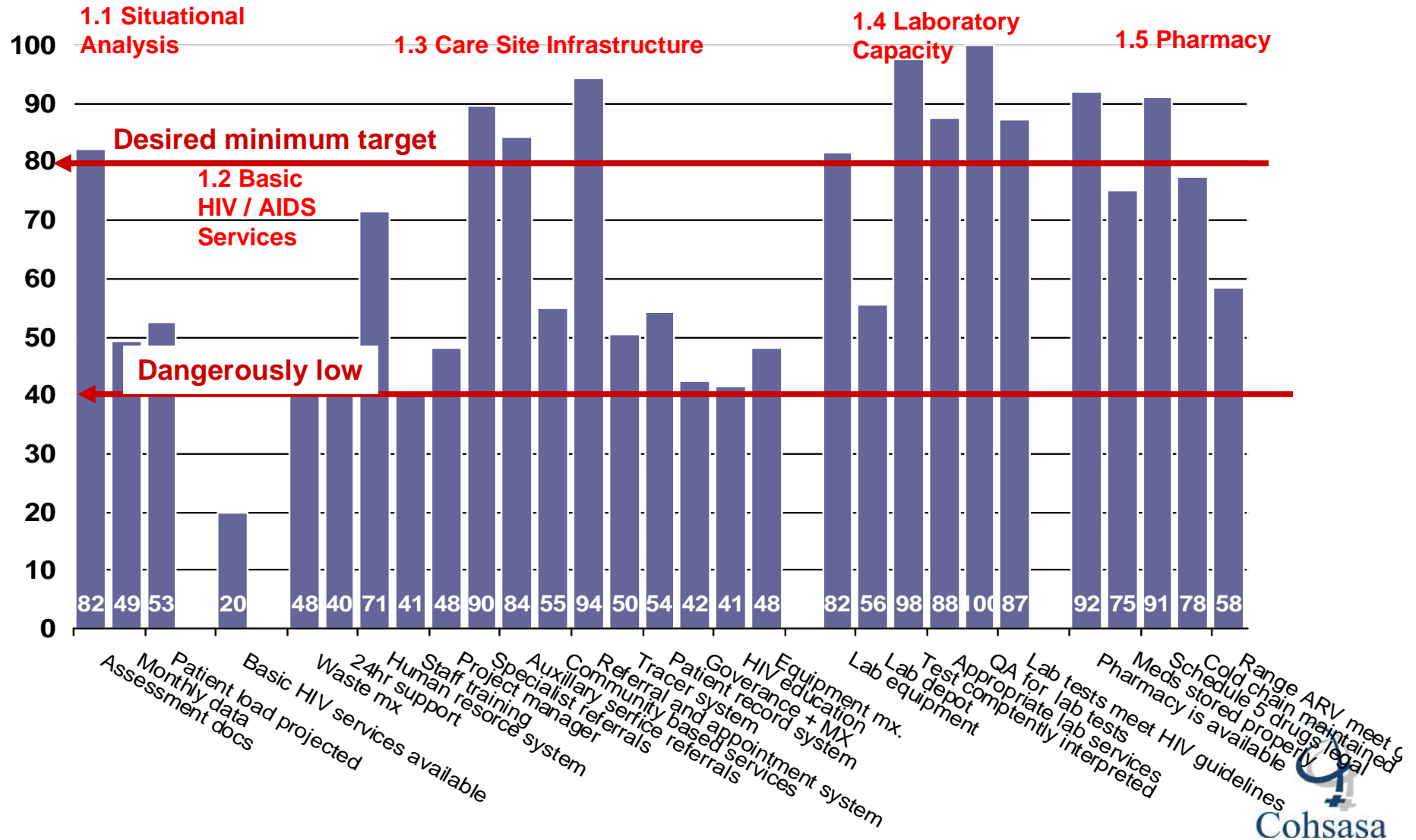
- Pharmaceutical service.
- Laboratory service.
- Radiology service.



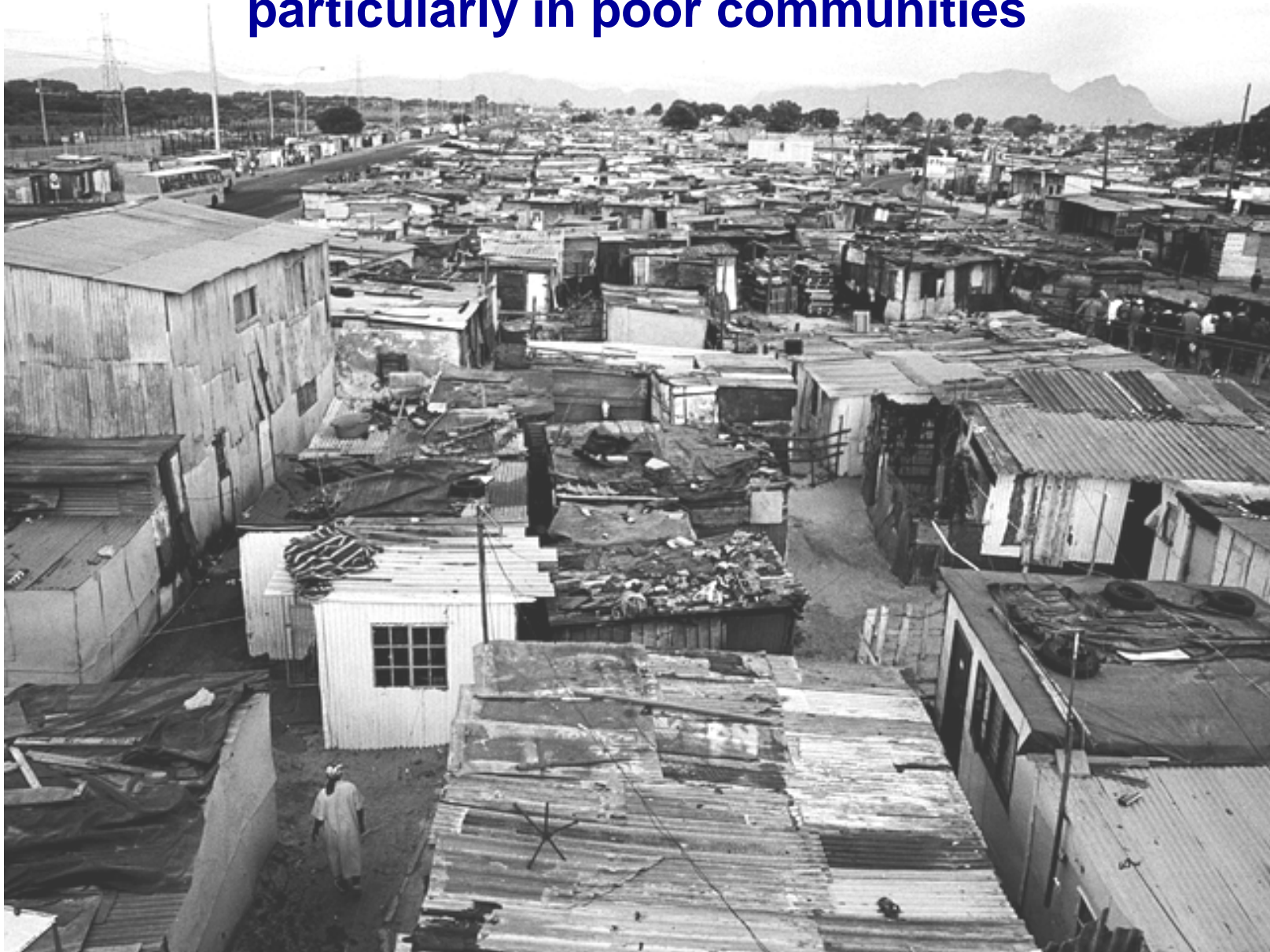
CCSET facilities' overall generic scores



Average CCSET standard compliance scores achieved by the group of participating facilities



Hence work is needed to bring facilities up to standard particularly in poor communities



But does ARV treatment work in poor communities?

South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005

Commissioned by the Nelson Mandela Foundation



**NELSON MANDELA
FOUNDATION**

Living the Legacy

Public sector HAART clinics

- 204 ARV clinics
- Dedicated teams
 - Doctors
 - Nurses
 - Lay counsellors
 - Pharmacists
 - Admin staff
- Some services are nurse-run with only initiation and supervision from doctor
- Public health approach with protocols



Caring together for life

Khomanani

National Antiretroviral Treatment Guidelines

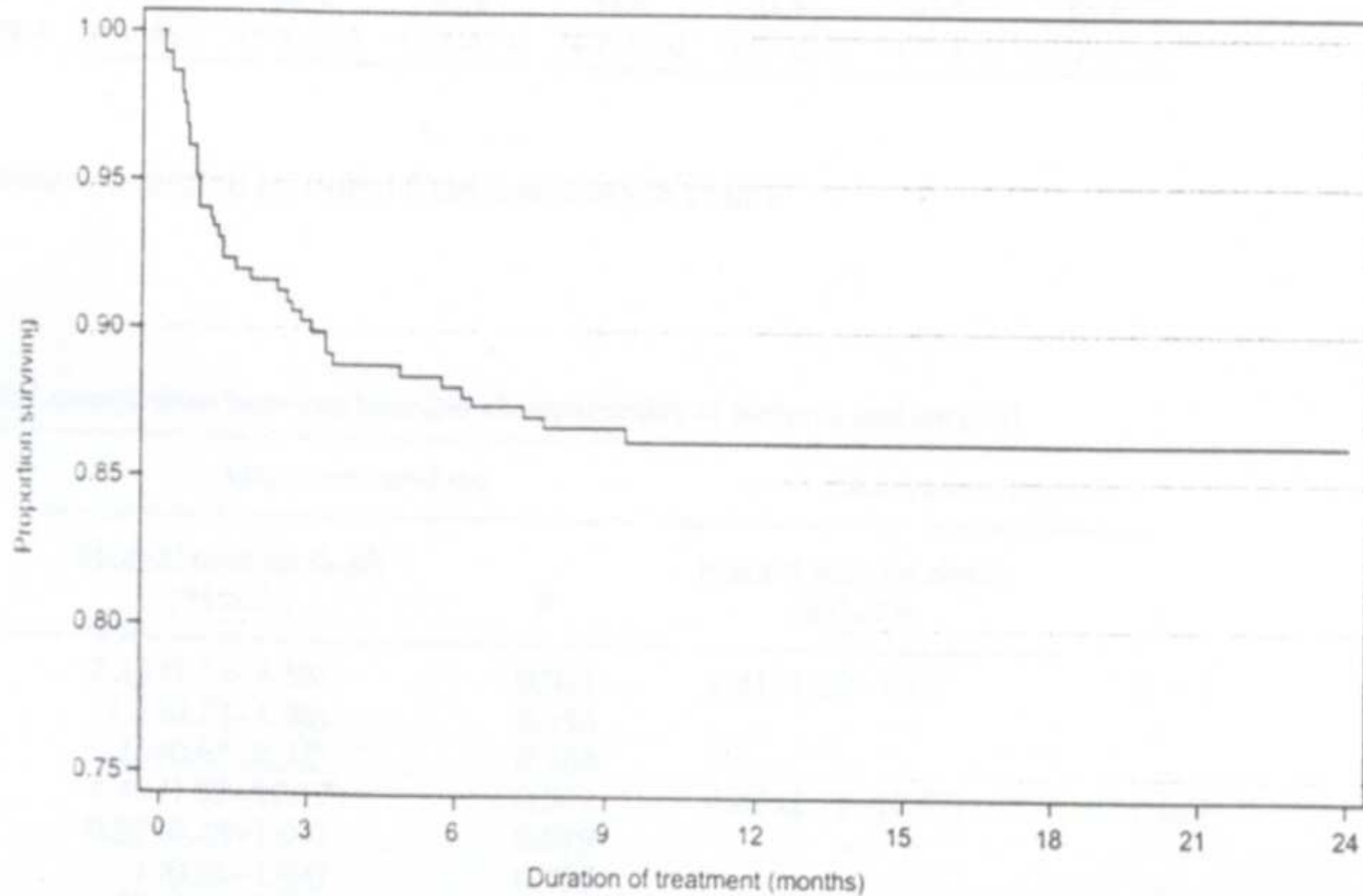
HIV AND AIDS POLICY GUIDELINE • DEPARTMENT OF

Western Cape

- HAART available in public sector at limited sites since 2001
 - MSF and other NGO's
- National roll-out since April 2004
- 43 ARV facilities
- 17 045 patients on treatment (April 2006)
 - Adults 14 960
 - Children 2 085
 - 60% at primary care sites

**Early mortality on HAART
MSF Khayelitsha (n = 287)**

Median CD4 = 43
52% prior AIDS diagnosis



Coetzee, AIDS 2004, 18: 887-895

4 year outcomes

- 23% died
- 1% lost to follow-up
- 3% transferred out

- 75% still in care

- 90% of these have VL < 400

SUCSESSES

- Adherence and viral suppression
- Reliable drug supply
- > 200 000 people on HAART, but far short of 3 by 5 target
- Simplified public health approach
- NGO involvement
- Mortality on HAART decreasing

PROBLEMS

- Political commitment
 - Confusing messages and silences from political leaders
- Late testing and late presentation
 - HAART started with low CD4 counts (median still 80 in Khayelisha)
- Drug toxicities
- Pregnancies on Efavirenz
- Prevention failures

Acknowledgements

- Andrew Boulle (UCT Public Health) for Western Cape cohort data

However, even if we get the systems right providing safe clinical care is difficult in the best hands.

Patient harm - 1 in 10 admissions to hospitals in developed countries without the severe impact of HIV+ disease

Because of this factor, steps are being taken to determine and learn from adverse event rates.

Both retrospective and prospective methodologies are being piloted. The knowledge gained will be used to improve patient safety

Planned augmented approach to improving performance in healthcare facilities

